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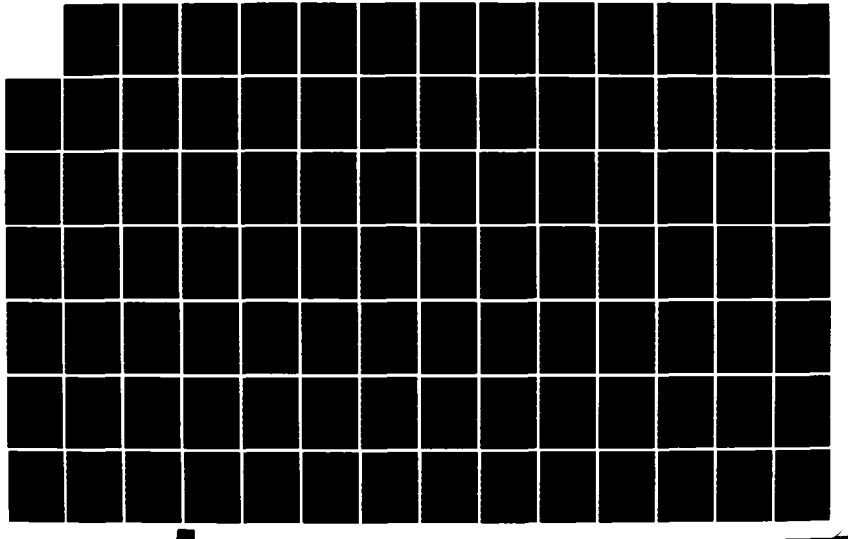

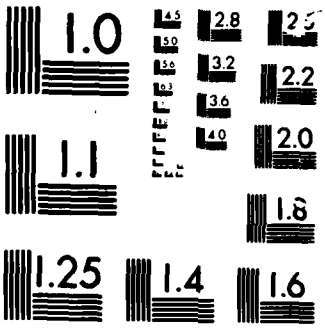

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Abstract of Thesis Presented to the Graduate School of the University of Florida in Partial Fulfillment of the Requirements for the Degree of Master of Science in Nursing

ROLE EXPECTATIONS FOR UNITED STATES AIR FORCE PSYCHIATRIC CLINICAL NURSE SPECIALISTS

Thomas M. Gormley
Captain, USAF, NC
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Chairperson: Martha J. Snider
Major Department: Nursing
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The purpose of this investigation was to describe and analyze role expectations for United States Air Force (USAF) psychiatric clinical nurse specialists (PCNSs) held by the PCNSs and their mental health and nursing colleagues, specifically: clinical psychologists, clinical social workers, generalist mental health nurses, nurse administrators, and psychiatrists.

A purposive sample was drawn from USAF medical facilities at which all groups were represented. Data were collected by mailed questionnaire.

Respondents perceived the actual USAF PCNS role to include 5 of 40 role enactment behaviors, but identified the ideal/expected role to include 39 of the same 40 behaviors. A weak, positive correlation was found between perceptions of and expectations for the USAF PCNS role. Respondent profession was found to significantly influence expectations for the USAF PCNS role.

The USAF PCNS role was found to be subject to conflicting expectations. These conflicting expectations may limit the PCNSs' effectiveness.

ROLE EXPECTATIONS FOR UNITED STATES AIR FORCE PSYCHIATRIC CLINICAL NURSE SPECIALISTS

By

Thomas M. Gormley

All the opinions stated are those of the author and not necessarily those of the United States Air Force.

A THESIS PRESENTED TO THE GRADUATE SCHOOL
OF THE UNIVERSITY OF FLORIDA IN
PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF MASTER OF SCIENCE IN NURSING

University of Florida

1986

To my wife.

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This thesis is the product of many people who gave from their time, talent, experience, and knowledge to aid in its completion.

My sincere thanks go to my graduate supervisory committee. Their thoughtful guidance, patience, and valuable knowledge as nurses and educators helped me surmount the insurmountable. A special thanks goes to my academic advisor, Karolyn Godbey.

Many members of the United States Air Force also contributed to the completion of this study. In particular, I wish to thank LtCol Margaret M. Marshall, the Surgeon General's Consultant for Mental Health Nursing, for her support. Maj Les Stratford provided valuable information needed for designing the study. This study would have been impossible without his contribution and those of each of the senior mental health nurses at the study locations who volunteered time from their already busy schedules to distribute the questionnaire. And finally, I sincerely appreciate the efforts of the study respondents, without whose cooperation the entire project would have come to naught.

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Chairperson

CHAPTER I
INTRODUCTION

The term Clinical Nurse Specialist (CNS) first appeared in the nursing literature in 1938 (Peplau, 1973). In 1943 the National League for Nursing Education, a forerunner of today's National League for Nursing (NLN), published the first standards for university based, graduate level programs to prepare CNSs for advanced practice in all clinical areas of nursing, including psychiatric nursing (Crabtree, 1979; Garrison, 1953; Peplau, 1982a). The 1946 National Mental Health Act defined psychiatric nursing as one of the four core mental health disciplines, stimulating rapid proliferation of graduate programs preparing psychiatric clinical nurse specialists (PCNSs) by providing grants and stipends (Garrison, 1953). Participants in the NLN's 1956 conference on the PCNS role clearly agreed the PCNS role was an entirely new one which required the development of new sets of expectations for role performance and new programs to produce role occupants (NLN, 1973a).

Expectations for the PCNS role in health care have been documented in the nursing and mental health literatures (Dudley, 1982; Fife, 1983; Wondra, 1974). These expectations for the PCNS role have different emphases in different practice settings. PCNSs in hospital-based

settings can expect to focus their practice on four sub-roles: expert practitioner, educator, consultant/change agent, and researcher (Clayton, 1984; Dudley, 1982; Gaines, 1981; Hamric & Spross, 1983). Hospital-based PCNSs have recognized that expectations for PCNS role performance will vary with the goals and services of the practice setting, the professional orientation and experience level of the nursing staff, the care requirements of the patients served, and expectations of other professionals within the setting (Blount, et al., 1979; Brown, 1983b; Cooper, 1973; Crabtree, 1979; Edlund & Hodges, 1983; Gaines, 1981; Fife, 1983; Fife & Lemler, 1983; Girouard & Spross, 1983; Noonan, 1976; Wondra, 1974).

Lack of specific information about the expectations for role performance in a specific setting may produce role confusion and ambiguity (Hamric & Spross, 1983). It is essential that hospital-based PCNSs understand what their nursing and mental health colleagues expect for PCNS role enactment in specific hospital-based practice settings. Understanding of these setting-specific expectations may enable PCNSs in that setting to cope more effectively with the PCNSs' current role position as well as to better effect changes in others expectations. The end result may be that the PCNSs themselves will function more effectively, the mental health team in the setting may function more efficiently, and the original purposes of the

PCNS--to improve patient care and the quality of nursing practice--will be achieved (Christman, 1973a; DeYoung et al., 1983; NLN, 1973b; Reiter, 1973).

The Need for the Study

Since 1982, United States Air Force (USAF) nursing leaders have identified that they require more than the current number of PCNS positions in the USAF health care delivery system to enhance the professionalism of nursing practice and improve the quality of patient care. The nurse leaders are prepared to commit funds to both provide full-time, on duty education for USAF generalist mental health nurses in NLN accredited graduate programs leading to PCNS qualification, and more actively recruit PCNSs from the civilian work force to fill these positions (M. Korach, personal communication, 15 May 1983). All USAF PCNS positions are hospital-based (Department of the Air Force, 1985; L. Stratford, personal communication, 13 Aug 1984).

Military hospital-based mental health settings have been described as markedly different from their civilian counterparts, but markedly similar and distinctive within each of the uniformed services as they share statutory and organizational similarities (Boystun & Perry, 1980). Statutory and organizational similarity of USAF settings are outlined in Air Force Regulation 168-4 and its associated regulations which govern the organizational structure and

the activities of personnel within all USAF medical treatment facilities (Department of the Air Force, 1983).

The Problem

Role expectations for PCNSs in the USAF hospital-based setting have not been previously studied (M. Marshall, personal communciation, 26 Oct 84). USAF PCNSs need to know the expectations for their role performance held by their USAF mental health and nursing professional colleagues. Understanding expectations for USAF PCNS role performance may enable USAF PCNSs to cope more effectively with their current role position and effect changes in others expectations as appropriate. This understanding may enable USAF PCNSs to function more effectively, contribute to the more efficient functioning of the USAF mental health team, and better facilitate the improvement of both patient care and nursing practice in USAF hospital-based settings.

Purpose

The purpose of this study was to describe and analyze role expectations for USAF PCNSs held by the PCNSs and their USAF professional mental health and nursing colleagues, specifically: clinical psychologists, clinical social workers, generalist mental health nurses, nurse administrators, and psychiatrists.

Research Questions

1. What role enactment behaviors do respondents identify for the actual/perceived role of hospital-based USAF PCNSs?

2. What role enactment behaviors do respondents identify for the ideal/expected role of hospital-based USAF PCNSs?

3. What is the relationship between the actual/perceived and ideal/expected PCNS role reported by respondents?

4. What is the relationship between respondent's professional group and ideal/expected role reported?

Definition of Terms

Clinical Psychologist

A graduate of a doctoral program in clinical psychology, holding a PhD or PsyD degree, who qualifies for Air Force Specialty Code (AFSC) 9181 or 9186, with or without suffix -B (Department of the Air Force, 1985; Shakow, 1980).

Clinical Social Worker

A graduate of a master's or doctoral program in social work who qualifies for AFSC 9191 or 9196 (Department of the Air Force, 1985; Meyer, 1980).

Generalist Mental Health Nurse (MHN)

A graduate of general undergraduate education in nursing, licensed to practice as a registered nurse, and who

qualifies for AFSC 9721 or 9726 [American Nurses' Association (ANA), 1982; Department of the Air Force, 1985; O'Toole, 1980].

Hospital-based PCNS

A PCNS assigned to the nursing or mental health departments of a USAF medical treatment facility.

Nurse Administrator

A registered nurse responsible for the management and administration of a nursing department who qualifies for AFSC 9711 or 9716 (Arndt & Huckabay, 1980; Department of the Air Force, 1985).

Psychiatric clinical nurse specialist (PCNS)

A nurse with a master's degree in psychiatric and mental health nursing who qualifies for AFSC 9726 or 9726-A (ANA, 1982; Department of the Air Force, 1985).

Psychiatrist

A physician graduate of an accredited medical school who has completed residency training in psychiatry and who qualifies for AFSC 9581 or 9586, with or without suffices -A or -B (Department of the Air Force, 1985; Haber et al., 1983).

Assumptions

Assumptions basic to this study were:

1. All respondents to the mailed questionnaire were USAF mental health and nursing professionals.

2. All respondents answered the questionnaire honestly.

3. There are role enactment behaviors in the hospital-based setting of USAF medical treatment facilities that are appropriate for the USAF PCNS role.

4. USAF mental health and nursing professionals at the identified USAF medical treatment facilities had knowledge of and expectations for the PCNS role in the USAF.

5. No past study of this type had been performed with this population.

Summary

The purpose of this study was to describe and analyze role expectations for USAF PCNSs held by the PCNSs and their USAF professional mental health and nursing colleagues, specifically: clinical psychologists, clinical social workers, generalist mental health nurses, nurse administrators, and psychiatrists. This chapter has introduced the topic of expectations for the hospital-based PCNS and the need for studying tnese expectations as they apply to the USAF hospital-based PCNS role. Further, it has stated the purpose of the study, the research questions, and the assumptions upon which this study was based.

CHAPTER II
LITERATURE REVIEW

The purpose of this study was to describe and analyze role expectations for USAF PCNSs held by the PCNSs and their USAF professional mental health and nursing colleagues, specifically: clinical psychologists, clinical social workers, generalist mental health nurses, nurse administrators, and psychiatrists. This chapter describes the conceptual framework and literature review for the study. First, the conceptual framework for the study, based on the symbolic interactionists' formulations on perception and role theory in formal organizations, will be reviewed. Then, the literature on expectations for the PCNS role will be traced.

Conceptual Framework

The conceptual framework for this study was derived from the perspective of symbolic interactionism. Symbolic interactionism provides a matrix within which to understand how humans perceive and interact with the world and with the society they create in this world, including roles as systems of human interaction.

Human Perception

Basic to understanding the process by which roles evolve in society is an understanding of human perception.

Role evolution, like all other forms of social behavior, is possible only because humans do not respond directly to stimuli, but to stimuli as placed into each person's own individual meaning system. As persons come into contact with others, they form impressions of these others based on their own behavior and the meaning of the otners' behavior to their own meaning system. Persons use these impressions to explain and predict others' behavior, imputing meaning to the behavior of others based on their own impressions of themselves (Albrecht et al., 1980).

Thus, meanings are mediated by the perceiver's understanding of the perceiver's own behavior and experience. Perceivers can give meaning to their perception of others' behavior only through attributing to that perception characteristics of themselves. Perceivers develop a sense of their own characteristics through reflection on their own experience of themselves and the meanings they derive from that experience. Knowledge of others results from awareness of oneself and others in relationship to each other (MacMurray, 1957).

Three statements can be made about the development of meanings as they affect human perception. First, humans act toward objects on the basis of the meanings the objects have for them. Second, the meaning of such objects arises out of social interaction with other persons. Third, these meanings are modified through an interpretive process

used by the person in dealing with those objects s/he encounters (Blumer, 1969). In this sense, object includes anything to which a person can refer. Objects are classified into three categories: physical objects, social objects (i.e., roles), and abstract objects (i.e., moral principles)(Blumer, 1969).

The nature of an object is the meaning the person referring to the object gives it. This meaning sets the way the person perceives, acts toward, and speaks of the object. An object's meaning must be seen as a social creation. This social creation grows from the process of group interaction, definition, and interpretation. Through the process of group interaction, the meaning of objects is constantly being formed, affirmed, transformed, and rejected (Blumer, 1969).

A role, then, can be seen as a social object. As a social object, persons perceive a role on the basis of their experience of it, and the meaning of that experience to themselves. But human experience constantly grows and changes through social interaction. The meaning, and thus the perception, of a role will also grow and change through social interaction.

Role Theory

The concept of role as a means of understanding patterns of human behavior arose concurrently in several disciplines in the first three decades of this century. The

theoretical framework for understanding role theory in this study is that tradition in social psychology derived from symbolic interactionism (Clayton, 1984). In this framework, role theory is concerned with expectations, identities, and social positions of humans in the context of their social structure (Biddle, 1979).

Role theory is the "science concerned with the study of behaviors that are characteristic of persons within contexts and with various processes that presumably produce, explain, or are affected by these behaviors" (Biddle, 1979, p. 4). The concept of role represents the totality of behavioral requirements which the context demands, or expects, from an individual (Katz & Kahn, 1978).

Biddle (1979) specified the definition of role depended on four terms: behavior, person, context, and characteristics. Behaviorally, roles are characterized only by those observable actions that apply to the person under study. Role can only be applied to the study of actions of persons. The role studied must be specified by the context in which it occurs. And finally, a role can be defined only in terms of the observable behaviors that are characteristic of a set of persons in a given context: that is, statements of enactment behaviors expected for the focal person in the role.

Generically, role behavior within the context of a given organization refers to recurring individual acts that

interrelate with others' activities to produce predictable outcomes. In the context of formal organizations, many of these expected activities are specifically written and are more a product of the setting than the personality of the role occupant (Katz & Kahn, 1978). The collection of these activities to be performed by a given occupant, and their relationships with other occupants within an organization, is termed a role set (Biddle, 1979).

Katz and Kahn (1978) point out that one of the formal organization's chief strengths is its constancy despite personnel turnover. The primary reward of organizational membership and satisfaction, derived from skillful and successful meshing of the role occupant's actions with those of the role-set members, then, grows from the process of learning others expectations, accepting these expectations, and fulfilling them.

Role expectations are prescriptions and proscriptions for the focal person's behavior held by members of the role set. Based on their beliefs and attitudes about which actions should and should not be performed by the role occupant, these expectations reflect the members' conceptions of the role's requirements. In aggregate, these expectations define the behaviors expected of the role occupant. Expectations may refer to specific actions to be done or not

done, as well as the style of accomplishing them. Expectations are communicated through the process of role sending (Biddle, 1979; Katz & Kahn, 1978).

Role sending involves all members of the occupant's role set. Role sending is a communicative and influential process involving desired content of the focal person's behavior. Content of the messages about expectations for a role may include behavioral instructions, information on performance-contingent rewards or penalties, and current performance appraisals. As attempts at influence, they may proceed along formal organizational or informal lines. From superiors, these may represent formal specifications of objectives and responsibilities. From subordinates and peers, they may be totally unrelated to official requirements and directed at making the sender's own role easier to fulfill (Katz & Kahn, 1978).

Role-sendings to the focal person only partially determine that person's role behavior. Compliance with, and deviations from, the sent role are strongly influenced by the focal person's perceptions of that sent role. The aggregate of sent-role perceptions is the received role. The congruence between this subjective interpretation and the actual role sendings will depend on senders' properties, the focal person, the substantive content of the expectations, and communication clarity. The received role

is the primary determinant and motivator of the focal person's behavior. If the role sendings are perceived as illegitimate or coercive, they may arouse strong resistance and lead to unintended effects. If role sendings are unclear, they may be perceived as ambiguous. Role messages may be misunderstood or defensively distorted. Persons may be socialized or professionally trained to enact their roles in response to factors other than communicated expectations. They may have already acquired a set of values and expectations about their role behavior as an occupational or professional self-identity. These acquired sets of values and expectations may interfere with the focal person's ability to adhere to communicated expectations, creating role conflict (Katz & Kahn, 1978).

The greater the degree of organizational formalization in rules and regulations, the greater the likelihood that professionals will experience conflict between their professionally acquired role expectations and the expectations for their role performance communicated by the organizational role set (Green, 1978). Shapiro, Haseltine, and Rowe (1978) suggested that the influence of senior members of the same profession within the organization may serve to lessen this conflict, and facilitate enactment of the communicated expectations for the role by the professional. This influence may be conceptualized on a continuum from passive to active involvement of the

senior professional with the junior one. The most passive influence, the role model, gives the fledgling professional freedom to pick and choose enactment behaviors and behavioral styles from numerous seniors while at the same time relieving the senior of the requirement to be a "total professional." The most active involvement arises in the mentor relationship, described as intense and paternalistic. The mentor actively promotes and shapes the career of the junior professional. Intermediate styles of influence are termed guide, preceptor, and sponsor, each progressively involving the senior professionals more actively in the socialization and career shaping of the junior ones (Shapiro et al., 1978). Influence by senior professionals, then, may facilitate successful role enactment by junior professionals through reducing the perceived conflict between professional and organizational expectations (Green, 1978).

The process of enacting an organizational role is simplest when it involves only one activity, is confined to one organizational subsystem, and relates only to a role-set entirely within that same subsystem. Additional activities, numbers of subsystem involvements, and numbers of role senders increase role complexity (Katz & Kahn, 1978).

Roles which link different subsystems, termed boundary roles, may be especially complex since each organizational subsystem may have its particular

priorities. With different priorities, conflicting expectations may be sent and received. Boundary linkages may be created in an organization through physical movement or by activities directed at coordinating roles in different subsystems (Katz & Kahn, 1978).

Communication of multiple role expectations, then, may increase the likelihood that compliance with one expectation will make compliance with others more difficult. This role conflict may be differentiated in terms of degree, ranging from mutual interference to absolute exclusion. This conflict may originate in differing expectations communicated by the same role-sender, between two or more senders, between expectations of the role-set and the focal person, or between roles held by the focal person. Role conflict can lead to decreased effectiveness of the focal person, as well as strain and hostility between role-set members. Visibility in role enactment by the focal person, as well as the focal person's coping strategy, may modulate these effects (Bederon et al., 1983; Katz & Kahn, 1978).

Katz & Kahn (1978) have proposed that organizational role evolution involves feedback about role enactment to the role-set members from the focal person. By this feedback mechanism, the role occupant communicates willingness or unwillingness to enact various role components. Confrontation with this feedback forces the role-set members to take alternative actions regarding unmet

expectations. These alternative actions may be corrective or compensatory, leading to closer approximations between expectations held by the role-set and the focal person as translated into role enactment behaviors. By this feedback mechanism, the focal persons may actively change role-set expectations for their role, shaping it to more closely meet their own expectations.

Operation of this feedback mechanism is hypothesized to require trust building within the role set by the focal person. Initial, successful enactments by the focal person of behaviors expected for the role are essential in this regard. These initial successful enactments provide the role set with reassurance that their own interdependant role performances will not be jeopardized or handicapped. With an increase in the trust and confidence among role set members, increasing consensus and decreasing conflict about the focal role may lead to increased satisfaction and an overall improvement in the efficiency of the role set in reaching its organizational objectives. Once the conflict level has decreased, pro-active behavior by the focal person to communicate expectations for their role that differ from those held by the role set are hypothesized to meet with less resistance. Trust building through active, visible enactment of the expected role behaviors may increase role set receptiveness to changing their expectations for the focal role (Katz & Kahn, 1978).

Organizational roles, then, can be seen to evolve over time. This evolution occurs as a result of complex interactions between members of the role-set and the focal person, or role-occupant. The role-set sends both formal and informal messages about the focal person's desired role enactment based on expectations for the focal person's behavior. These expectations are, in turn, based on formal organizational specifications as well as pre-existing personal and professional socialization. For the professional in a formal organization, more senior professionals may influence a junior's responses to these sent-role expectations. Responses of the focal person to this sent role will be to meet the sent expectations, attempt to change them in some way, or to leave the organization. Attempts at changing role expectations are directed toward decreasing conflict between the received role and the role occupant's own expectations for how the role should be enacted. By a cyclic process of successive approximations, greater agreement is reached between the role-set and focal person on role appropriate behaviors.

Role Expectations for Hospital-Based PCNSs

This section examines expectations for the role of the hospital-based PCNS as reported in the mental health and nursing literatures. First, the evolution of the role will be traced. Then relevant information drawn from the nursing

and mental health literatures reflecting current expectations for this role will be reviewed.

Historical Overview

Peplau (1982a) traced the evolution of education preparing PCNSs at the master's level for the NLN's 1956 Working Conference on Graduate Education in Psychiatric Nursing held at Williamsburg, VA. This review found origins of clinical specialization in mental health nursing in the post-graduate programs of the 1920's and 1930's. These programs, based in psychiatric hospitals, were designed to prepare graduate nurses for leadership roles in the mental health area. Both the National League for Nursing Education and the American Psychiatric Association, through its nurse branch, encouraged these post-graduate programs in an effort to improve patient care in the hospitals of that time. These programs varied in length from two to six months, and 14 were in existence in 13 states in 1931. Graduates of these programs were the forerunners of today's PCNSs. They were the ones to whom physicians and hospitals turned in search of expert practitioners, teachers, supervisors, and administrators. Peplau (1982a) noted tnese programs continued until after the advent of university-based graduate psychiatric nursing education in 1943.

The actual articulation of the need for graduate education in nursing, formulation of these programs'

objectives, and definition of role expectations for graduates of these programs fell to the National League for Nursing Education (NLNE). Through a series of "Round Tables" held between 1940 and 1945, the NLNE mapped the basic plan of education to be followed, standards to be met, and goals for producing advanced clinical practitioners of nursing (Peplau, 1982a). While Crabtree (1979) and Garrison (1953) credit Frances Reiter with the first use, at one of these NLNE meetings in 1943, of the term Clinical Specialist to describe this new role, Peplau (1973) elsewhere states the term was in existence by 1938.

The first graduate level programs in psychiatric nursing began in 1943, and by 1945 had graduated 126 students. These programs primarily focused on producing graduates for roles as administrators and educators in nursing (Peplau, 1982a). Peplau started the first program to prepare PCNSs with an exclusive focus on expectations for advanced nursing practice at Rutgers University in 1955 (Peplau, 1982b; Wyers et al., 1985).

Graduates of the Rutgers PCNS program were expected to work directly with patients, individually and in groups, demonstrating and experimenting with new patterns of nursing care while deriving new knowledge from empirical observations in nursing practice. All expectations were stated as providing or demonstrating direct care to patients. Consultant expectations were implied in the

statement "to serve as a resource to ward personnel" (p. 48) as were clinical supervision, in addition to the clinical practice and research expectations noted above. No stated expectations for the PCNS program graduates included administration, formal teaching, or work supervision behaviors (Peplau, 1982b).

To assess the opinions of others about these expectations, in 1955 the Rutgers faculty surveyed 15 physician and 23 nurse leaders at psychiatric facilities in the Newark, NJ, area. Results indicated concern with anticipated difficulty funding positions for PCNSs. Further, respondents had difficulty clarifying the differences between expectations for PCNSs and those they held for nursing supervisors and teachers, several suggesting that PCNSs also be prepared to fulfill these latter two sets of expectations in addition to the direct clinical ones. Respondents anticipated resistance to this new kind of nurse, and conflict with other nurses, psychiatrists, psychologists, and social workers was predicted. Predicted conflict included institutional inertia, and especially restriction and sabotage of the PCNSs' work based on a desire to maintain the stereotype of nursing in psychiatric facilities. Strong administrative support for the PCNSs and a strong public relations effort by the PCNSs themselves were recommended (Peplau,

1982b). The following year, the NLN's 1956 conference concluded:

> The purpose of the clinical specialist in psychiatric nursing remains clear--to bring about advances in the art and science of psychiatric nursing and to promote the application of new knowledge and methods in the care of patients. Investigative and consultant functions are implied in this purpose, but other functions may well appear as psychiatric nursing specialists carve out their jobs. It is up to them to establish their place in the pattern of organization and create channels of communication with other nursing personnel, members of other disciplines, and, possibly, with the community. (NLN, 1973a, p.8)

Current Expectations for PCNSs

As expressed in the nursing literature, expectations for the PCNS role in the hospital-based setting have currently stabilized around four major areas of role enactment behavior: expert practitioner, educator, consultant/change agent, and researcher (Clayton, 1984; Gaines, 1981; Hamric & Spross, 1983). Hospital-based PCNSs have agreed with nursing leaders that the purposes of the PCNS in the hospital environment are to increase the professionalism of nursing practice and improve patient care (Christman, 1973a; Fife & Lemler, 1984; Peplau, 1973; Reiter, 1973). Further, hospital-based PCNSs have recognized in the literature that expectations for their role performance will vary with the goals and services of the practice setting, the professional orientation and experience level of the nursing staff, the care requirements of the patients served, and expectations of other professionals within the setting (Blount, et al., 1979;

Brown, 1983a; Cooper, 1973; Crabtree, 1979; Edlund & Hodges, 1983; Fife, 1983; Fife & Lemler, 1983; Gaines, 1981; Girouard & Spross, 1983; Noonan, 1976; Ropka & Fay, 1984; Wondra, 1974). Spross & Hamric (1983), however, suggested that the role is a dynamic one, and expectations for it will constantly change as the setting within which it is enacted changes. This section examines expectations for these four areas of PCNS role enactment behavior, and explores how they may be expressed.

Expert practitioner expectations

Expert practitioner has remained the core of hospital-based PCNS role expectations. The PCNS has been expected to perform direct, expert psychotherapeutic care with patients, groups, and families in all clinical areas of the hospital-based setting. By demonstrating expertise in nursing practice, the PCNS has been expected to provide generalist nursing personnel with a role model upon which to base improvement in generalist nursing practice. Formulation of mental health and nursing diagnoses have been included in PCNSs' expectations for their role enactment (ANA, 1982; Fagin, 1981; Fife, 1983; Kuntz et al., 1980; Mitsunaga, 1982).

Educator expectations

Reported role enactment behaviors expected of PCNSs as educators have been basically of two types. The first type has been the expectation to provide educational

opportunities to patients and their families. In addition, PCNSs have been expected to engage in formal and informal teaching of nursing staff based on their clinical expertise in psychiatric/mental health nursing (NLN, 1973b; Cohen, 1973; Fife, 1983; Kuntz et al., 1980). An aspect of this role reported by Fife and Lemler (1983) was that of preceptor to neophyte nurses in all clinical areas, especially during the neophytes' internships. This activity by a PCNS at a study facility was associated with decreased turn-over in the nurse intern population.

Consultant/change agent expectations

Expectations for PCNS role enactment as consultant/change agent have been based upon the PCNSs' understanding of stress and its effects as well as their ability to work with others on problem solving. Hospital-based PCNSs reported consultation activities mainly as client case-centered, direct nursing care to patients in non-mental health areas of the health care facility, and as consultee-case centered, in the form of nursing case conference and clinical supervision of generalist nurses (Fife & Lemler, 1983; Gordon, 1973; Ropka & Fay, 1984). Barbiasz et al. (1982) and Morath (1983) discussed the advantages of having a consultant PCNS available to the division of nursing from a staff position within the division. This PCNS served as a "trouble shooter," performing system oriented consultation for the

division to improve delivery of patient care services, and in support of staff development services by performing entrance and exit interviews.

Researcher expectations

The researcher expectations for PCNSs have been those least frequently reported in the literature. Most PCNS reports of activities to meet researcher expectations appeared as clinically centered articles on activities in patient care and attempts to define new systems of nursing practice. These activities are consistent with Peplau's original formulation (Hodgman, 1983).

Other expectations for the hospital-based PCNS role

With increasing pressures to contain costs, many nursing service directors have reported difficulty justifying a purely clinical PCNS. In an attempt to retain the PCNSs' advanced nursing expertise, these directors have experimented with placement of the PCNS within the hospital hierarchy.

Most reported attempts to retain PCNS expertise have centered on finding a place for the PCNS within the hospital administrative hierarchy. Reports have included PCNSs functioning as head nurses, clinical coordinators, and supervisors, all of which add administrative expectations to the hospital-based PCNSs role. A tendency for administrative expectations to override all others has also

been noted by Edlund & Hodges (1983), Morath (1983), and Wallace & Corey (1983). Butts (1974) and DelBueno (1976), however, doubted strongly that a hospital-based CNS of any type will ever prove cost-effective in any role except a strictly administrative one.

Research on Expectations for PCNSs

This section reviews published research on expectations for the PCNS role in the hospital setting. Several of the studies report on Clinical Nurse Specialists as a group, with PCNSs as a subgroup of the overall sample, while others examine the PCNS in hospital and other settings.

Clinical nurse specialist

Baker and Kramer (1970) studied expectations for CNS role enactment held by nursing service directors at 37 medical centers. Respondent directors identified the primary goal of the CNS to be improvement of patient care. To achieve this goal, CNSs were expected to provide both direct and indirect patient care. Direct care was defined as actual patient care, patient teaching, including discharge instruction, following up referrals, and staff teaching in nursing team conferences. Indirect care was defined as new staff orientation, consultant to nursing staff, and staff development through inservice education. One-third of responding directors specifically identified a "trouble shooter" role for CNSs, both patient and staff centered, throughout the

medical centers involved regardless of the CNSs' position within the centers' hierarchy. Respondent directors identified that, despite these overall expectations, each CNS was to develop their own functions and gain acceptance and authority within the medical center by demonstrating clinical skill and competence. Most directors placed CNSs in the medical centers' hierarchy to report directly to the director administratively from a staff position in nursing service, but others placed the CNS in a line position with administrative authority over one or more nursing units. A third alternative reported was placement of the CNS in the medical center nursing staff development service. Baker and Kramer concluded the CNS must begin practice with expectations clearly and mutually defined with the nursing service director. They also found that expectations for CNS role performance will vary with the structure of the setting in which it is enacted and expectations of others within the setting.

Boucher (1971) studied expectations for CNS role enactment held by nurse educators, CNSs, nurse administrators, and nurse practitioners in the Northeast. Respondents to Boucher's survey saw the CNS primarily as a researcher and educator both within the inpatient setting and in the community. No respondent group envisioned the CNS to be primarily involved in direct patient care. No clear relationships between respondent

demographic characteristics and expectations for tne CNS role were found.

McVay, Reihl, and Chen (1973) surveyed a sample of deans of baccalaureate and higher degree programs to determine their expectations for the CNS role, including the PCNS role. Respondent deans identified that they expected the CNS role to include a combination of practice, continuing education activities, and research with publication of findings. Analysis of the data indicated respondents ranked practitioner expectations as most important, with expectations for educator, consultant, researcher, administrative supervisor, and change agent in order by descending importance.

Dunn (1979) described the CNS role and compared physician and registered nurse (RN) colleagues' expectations for the CNS role to that description. CNSs were found to define their role in terms of patients' needs. Physician and RN colleagues, however, defined the role in terms of their own needs and priorities so that, while the three groups were in general agreement on CNS role enactment behaviors, expectations for the priority of various enactment behaviors varied by discipline. Physicians focused on their own care giving activities and expected the CNS to serve as a resource for them, particularly by performing delegated medical tasks. RNs perceived the CNS to be an expert consultant on nursing care, and expected

the CNS to function as a non-medical resource for them. Neither colleague group saw the CNS role primarily focusing on direct provision of nursing care. The author concluded the physicians' expectations would be problematic in the evolution of the CNS role.

Clifford (1981) surveyed 192 employers and 152 educators of hospital-based clinical specialists in the mid-western United States to elicit their expectations for the clinical nurse specialist role. Participants were asked to complete a questionnaire on four components of the CNS role: practitioner, educator, researcher, and administrator. Both respondent groups were in general agreement that hospital-based clinical specialists' most important function was practitioner, with educator and researcher ranked second and third, while administrator functions ranked least important.

Gaines (1981) studied expectations for the CNS role in a convenience sample drawn from 14 southeastern hospitals held by 55 clinical nurse specialists, 28 nurse administrators who directly supervised these CNSs, and a randomized selection of 57 staff nurses clinically supervised by the clinical specialists. This study found great variability in expectations for the CNS role. The only area of agreement for the CNS role was found in educator expectations. Associations between age, years of practice experience, and education level and expectations

for clinical nurse specialist role enactment were found to vary between groups. Gaines concluded the findings indicated study CNSs of all types occupied boundary roles within the hospital setting, and, as boundary role occupants, were vulnerable to role strain, ambiguity, and conflict. Differences between respondent groups in reported expectations for the CNS role were attributed to faulty sending of role expectations.

Ropka and Fay (1984) surveyed expectations for CNS role performance held by a national sample of 500 directors of nursing. Descriptively, PCNSs were found to be the most frequent type of hospital-based CNS even in institutions having no specified mental-health setting. Expectations for consultant, educator, and quality assurance behaviors outranked direct patient care in importance for the respondents. Fewer than 10% of respondents identified administrative enactment behaviors as appropriate for CNS role performance.

Psychiatric clinical nurse specialists

Wondra (1974) surveyed 291 nursing and mental health professionals in two Arizona cities to determine which activities these professionals considered appropriate for PCNSs. Respondents practiced in various hospital and clinic settings, as well as teaching in colleges and universities. Findings indicated that nurses with a diploma in nursing or a person with a doctorate in any field identified fewer role

enactment behaviors as appropriate for PCNSs than the overall sample. Male and psychiatrist respondents reported a narrower view of PCNS function than females or non-psychiatrists. Past exposure to a PCNS as well as practice in hospital or community mental health clinic settings was associated with a broader interpretation of PCNS role-appropriate behaviors. Overall, respondents clearly identified the PCNS role to be differentiated from the traditional role of the nurse, and to include the following role enactment behaviors: primary therapist in all treatment modalities, consultation to hospital staff and community groups, community case finding and screening, and engaging in research. More traditional nursing roles of teacher, supervisor, and administrator were also included.

Mullaney, Fox, and Liston (1974) studied PCNS and clinical social worker expectations for their own and each others' roles. General agreement was found between tne groups that the PCNSs should focus their practice on patient care and nursing staff development enactment behaviors while clinical social workers should focus on serving as a liaison between patients and social service agencies. Both groups expressed strong interest in closer collaboration on supportive psychotherapeutic activities with patients, development of nursing care plans with nursing staff, and staff development activities. While 95% of respondents

reported interprofessional contact with the other professional group, 66% of these contacts were reported to be dissatisfying. PCNSs perceived clinical social workers to follow-up poorly on patient interventions while the social workers perceived the PCNSs to be inadequately prepared for supportive patient counseling and reluctant to accept clinical supervision for psychotherapeutic relationships.

Noonan (1976) surveyed 125 PCNSs and 273 clinical social workers from various in- and outpatient settings in New York state. Social workers viewed PCNSs' most important role as that of consultant to nursing staff, with supervision and participation in staff development activities ranked second and third, and participation in interdisciplinary team meetings ranked as fourth. Direct patient care functions of therapist in any modality were rated lower. In fact, social worker respondents viewed PCNSs as poor team members who were not well prepared clinically.

Davidson et al. (1978) surveyed 464 psychiatrists in a northeastern state on their perceptions of the PCNS role. Over half of the respondents were favorable to the PCNS as a full colleague on the mental health treatment team. Psychiatrists with past direct experience with a PCNS, those with more knowledge of the PCNS role, and those who used an analytic framework in their clinical practice

were more favorable to expanding PCNS practitioner functions than those who lacked these characteristics. No relationship between respondent's age, sex, length of clinical practice, or amount of exposure to public sector practice and favorableness to expanding the PCNS role was found.

Bird, Marks, and Lindley (1979) discussed their program to train graduate nurses to fulfill a broader role in British mental health care delivery. They mentioned reactions of non-nurse mental health professionals to their program. They found older, academically oriented psychiatrists were skeptical of the project and unwilling to be involved in the program. However, psychologists were the most opposed group, citing nurses' traditional medical orientation and academic naivety as making them unsuitable for a broader therapist role.

Fleming and Davis (1980) reported on the attitudes of 100 nurses in a sample, drawn from the Alabama State Nurses' Association's psychiatric/mental health nursing area of interest list, toward PCNSs performing psychotherapy. They found a positive correlation between educational level and openness to PCNS psychotherapists. Further, nurse educators were most favorable, nurses practicing in governmental facilities less so, and nurses practicing in general hospitals least favorable to PCNSs practicing psychotherapy.

Dudley (1982) used Gaines'(1981) instrument to study 93 Florida nurse administrators' expectations for hospital-based PCNSs. Most respondents identified the practitioner role as most important for the hospital-based PCNS, with less preference for the roles of educator, researcher, and administrator. No significant predictor characteristics were found with the variables of age, education level, or years of experience as a nurse.

DeYoung, Tower, and Glittenburg (1983) replicated their earlier study by interviewing groups of non-PCNS mental health providers about their perceptions of and expectations for the PCNS. They noted that psychiatrists tended to view the PCNS as a semi-professional or physician extender. Clinical psychologists, in contrast to earlier espoused views, were in total opposition to the PCNS in an expanded role. Psychologists in the earlier study glorified "non-pursuit of degrees" but in this later study insisted that a master's degree in nursing was not the "right kind of degree" to perform expanded practitioner functions, particularly psychotherapy. Clinical social workers surveyed saw themselves caring for well patients and performing psychotherapy of various types, and nurses as caring for the sick, especially the chronically mentally ill patient. All three of these groups tended to view PCNSs, and nurses in general, in a more traditional role of inpatient care givers or as public health nurses, with

the real work of the mental health team being performed by the group providing the perception.

Other factors affecting expectations for the PCNS role

Barger (1983) has noted that nursing, from an interprofessional standpoint, is deviant. She noted that society in general, and physicians in particular, expect nurses to be physicians' helpers, and consider nursing to be a para-medical group whose practice depends on that of physicians. This contrasts with nursing's own view of itself as a professional group capable of independently providing nursing care to patients based on an equal, collegial relationship with other health care professions: that is, a professional practice model.

Weiss and Remen (1983 a & b) have supported this view with research results from studies performed in the San Francisco, CA, area with groups of physicians, nurses, and consumers. Not only did they find that this view prevailed in their sample, but also that nurses perpetuated it by prolonged internal arguments over scope and entry into practice issues that made little sense to non-nurse observers. Content analysis of nurse interactions in the experimental group setting demonstrated that nurses were not assertive, not strongly identified with their profession, rarely spoke except to perform group maintenance functions of clarifying and facilitating interactions between non-nurse group members, and often allowed

themselves to be scapegoated for interpersonal conflicts between consumers and physicians in the groups. Nurses did not articulate clearly their alternative to the expected physicians' helper role enactment behavior. The authors concluded these findings supported the argument that nurses' own behaviors reinforce others expectations for nurses to be passive physician assistants.

Fagin (1981) and DeYoung, Tower, & Glittenburg (1983) have noted that studies of the mental health team performed by non-nurses rarely mention nursing at all, or, if they do, it is in a restricted, traditional sense. One such study was that of Zander, Cohen, and Stotland (1957). These researchers defined nursing as an occupational group peripheral to the central mental health professions of psychiatry, psychology, and social work in their study of role relations on the mental health team. They suggested their findings indicated that threats to the status of any of these groups from outside the hierarchical system of the three will be met by efforts to decrease the perceived danger. They found that occupants of superior roles, defined as psychiatrists, attempted to maintain control over threatening subordinates by defining their roles as designed to assist the superior, attempting to influence assignments of subordinates to guarantee they remained so, avoiding professional interactions with those not performing assistant

functions while at the same time minimizing non-compliant subordinants' competence to perform these non-dependant functions, and had negative feelings about the aspirations of these subordinates (Zander et al., 1957). Relationships between subordinate groups, defined as psychologists and social workers, were of two types. If one subordinate group saw the other as potentially supportive, they sought interprofessional contact with them and worked to win their admiration and respect. If, on the other hand, the other group was viewed as not supportive to the perceiving group's own interests, the perceiving group tended to avoid contact with the others, and attempted to decrease the others' influence within the health care system (Zander et al., 1957). In a similar vein, Brill (1977) suggested that nursing be recognized as a valid career rung on the ladder to a medical degree, and that psychiatric nursing be considered a way station on the road to a psychiatric medical degree if the candidates choose to advance in their careers.

The PCNS in the USAF

The first official recognition of the PCNS role in Air Force Regulation (AFR) 36-1, the USAF regulation which describes officer specialty codes (AFSCs), was in the 1977 revision of the regulation (Department of the Air Force, 1977). The PCNS position was appended to that of the generalist mental health nurse, AFSC 9726, with tne

suffix "A." However, no additional responsibilities or areas of function were added to the generalist mental health nurse specialty description. This lack of differentiation continues in the current officer specialty regulation (Department of the Air Force, 1985).

PCNS have practiced in the USAF since at least 1972. At the time of this study, their positions were officially designated at several USAF medical treatment facilities, and 10 were currently practicing at seven locations in the USAF with plans to introduce more as manpower allocations and funding became available (Department of the Air Force, 1985; M. Korach, personal communication, May 1983; M. Marshall, personal communication, 26 October 1984; L. Stratford, personal communication, 13 August 1984).

Military hospital-based mental health settings have been described as markedly different from their civilian counterparts, but markedly similar and distinctive within each of the uniformed services as they share statutory and organizational similarities (Boystun & Perry, 1980). Statutory and organizational similarity of USAF settings are outlined in AFR 168-4 and its associated regulations which govern the organizational structure and the activities of personnel within all USAF medical treatment facilities (Department of the Air Force, 1983).

Role expectations for PCNSs in the USAF hospital-based setting have not been previously studied (M. Marshall, personal communication, 26 Oct 84). USAF PCNSs need to know the expectations for their role performance held by their USAF mental health and nursing professional colleagues. Understanding expectations for USAF PCNS role performance may enable USAF PCNSs to cope more effectively with their current role position and effect changes in others expectations as appropriate. This understanding may enable USAF PCNSs to function more effectively, contribute to the more efficient functioning of the USAF mental health team, and better facilitate the improvement of both patient care and nursing practice in USAF hospital-based settings.

Summary

Nursing's ability to meet the challenges of the coming years and to define itself clearly to other professional groups rests on clearly understanding what expectations these groups have for nursing. PCNSs, as a sub-group of nursing, similarly need to understand others expectations for them and analyze how closely these match the PCNSs' own expectations. These expectations must be understood if PCNSs are to understand their position on the health team. Understanding of others' expectations may lead to understanding how these expectations affect PCNS role performance. With this information, not only may PCNSs be in a better position to understand themselves, but

also in a better position to effect changes in others expectations for PCNS role enactment behaviors. With these changes and adjustments, PCNSs would be in a better position to contribute more effectively to the mental health team, the mental health team would function more efficiently, and patient care and nursing practice would be improved (Barger, 1983; DeYoung et al., 1983).

The purpose of this study was to describe and analyze role expectations for USAF PCNSs held by the PCNSs and their USAF professional mental health and nursing colleagues, specifically: clinical psychologists, clinical social workers, generalist mental health nurses, nurse administrators, and psychiatrists. This chapter has presented the conceptual framework and literature review to support the study.

CHAPTER III
METHODOLOGY

Although PCNS has been a designated USAF specialty code, and the PCNS generic position description has been contained in Air Force Regulation (AFR) 36-1, attachment 27, since 1977, this position description did not clearly differentiate the role of the PCNS from that of the generalist mental health nurse. No specific information had been gathered concerning what role USAF PCNSs actually performed in USAF hospital-based settings. Expectations for their role held by the USAF PCNSs or their mental health or nursing professional colleagues had not been previously studied. This chapter describes the methodology of the research design used to gather this missing information.

Research Approach

The purpose of this study was to describe and analyze role expectations for USAF PCNSs held by the PCNSs and their USAF professional mental health and nursing colleagues, specifically: clinical psychologists, clinical social workers, generalist mental health nurses, nurse administrators, and psychiatrists. A mailed questionnaire was used to reach the largest number of potential respondents, reduce expenses as compared to site interviews, assure respondent anonymity, and avoid

interviewer bias (Polit & Hungler, 1983). The researcher's intent was to factually and accurately describe the respondents and their perceptions of, and expectations for, the USAF PCNS. The extent to which specific expectations for the USAF PCNS role, the dependant variables, varied in relation to respondent professional group, the independant variable, was also analyzed. A descriptive study with a correlational design was deemed the most appropriate means to elicit and analyze these data (Polit & Hungler, 1983).

Sample Selection

A purposive sample for this study was drawn from those clinical psychologists, clinical social workers, MHNs, nurse administrators, PCNSs, and psychiatrists currently practicing at USAF medical treatment facilities where at least one member of each group was assigned. The most current listing of USAF medical treatment facilities meeting this criterion was obtained from the USAF Military Personnel Center, Randolph AFB, TX. Six USAF medical facilities were found with representatives from all six professional groups. At these six facilities, there were 30 clinical psychologists, 24 clinical social workers, 59 MHNs, 20 nurse administrators, 9 PCNSs, and 42 psychiatrists assigned (L. Stratford, personal communication, 13 Aug 1984). These 184 mental health and nursing professionals constituted the

population for the study. The sample consisted of respondents to the questionnaire.

Instrumentation

A review of the relevant literature found seven instruments that have been used to analyze roles of generalist mental health nurses, PCNSs, and clinical nurse specialists (Aradine & Demyes, 1972; Clifford, 1981; Davidson et al., 1978; Gaines, 1981; Noonan, 1976; Pfeiffer, 1979; Wondra, 1974). None of these preexisting instruments were judged appropriate for this study, even with modification. Therefore, an instrument specific for this study was designed by the researcher. This instrument was based on: the researcher's interpretations of the previous survey instruments; current ANA (1982) standards of practice for psychiatric and mental health nursing; AFR 36-1, atch 27, Officer Specialities; and the researcher's knowledge of actual USAF practice.

This researcher-developed questionnaire consisted of three parts (see Appendix A). Part A collected descriptive information about study respondents: respondents were asked to provide information about their professional group, sex, age, professional qualifications and education, years and areas of practice, and type of professional exposure to USAF PCNS activity. Part B consisted of a paired, 40-item Likert-type scale of possible role enactment behaviors for a PCNS listed in two columns: "Actual" and "Ideal." The

column headed by "Actual" was termed the "actual scale," while the column headed by "Ideal" was termed the "ideal scale." Part C asked respondents to rate the degree of usefulness they expected a USAF PCNS might have in each of 12 ideal practice positions, again on a five-point Likert-type scale. This scale was termed the "ideal position scale." Finally, part C also included an open-ended "Comments" section. This section allowed respondents to elaborate if they wished, perhaps providing additional information on expectations for USAF PCNSs not otherwise captured in the structured portion of the questionnaire.

Pilot Study

A pilot study was conducted to assess content validity and internal consistency of the questionnaire. Ten subjects in a southeastern university city were contacted and agreed to participate. All subjects were PCNSs. Eight were practicing in hospital-based settings and two were nursing graduate faculty in a university program preparing PCNSs. Hospital-based PCNSs practiced in one community hospital and two medical centers, one federal and the other university-affiliated. Subjects were asked personally and in a cover letter to: self-administer the questionnaire; note the time required to complete it; comment on the clarity of instructions, format, and questions; comment on the thoroughness with which items

in Part B described the possible range of hospital-based PCNS role enactment behaviors; and, offer suggestions for improvement.

Pilot Study Results

Nine useable questionnaires were returned by the subjects in time to be included in the analysis of the pilot study data. Questionnaire completion time averaged 20 minutes. Numerous suggestions were offered to clarify instructions and items in parts B and C. Internal consistency, as computed by Cronbach's alpha, was found to be 0.83 for the actual scale, and 0.95 for ideal scale. The Cronbach's alpha for the position scale was computed and found to be 0.75, rated as adequate for such a short scale. The measure of correlation between responses to the actual and ideal scales, as computed by Spearman's Rank Order Coefficient, was found to not be statistically significant (Schefler, 1984; Waltz et al., 1984). Based on the results of this pilot study, the tool was revised to the form shown in Appendix A.

Procedure

The senior mental health nurse at each of the six identified USAF medical treatment facilities was contacted by telephone, informed of the nature and purpose of the study as well as its approval by the USAF and University of Florida College of Nursing, and his/her cooperation enlisted to distribute questionnaire packets at

that facility. With their agreement, a package containing a signed cover letter (see Appendix B) and questionnaire packets for potential respondents at their facility was mailed to each nurse. A response card acknowledging package receipt was also included for return to the researcher.

Both over the phone and in the cover letter the senior mental health nurses were asked to distribute the packets to potential respondents, either in person or by distribution mailbox, until all received packets were distributed. Two weeks after the researcher received the package receipt notification from the nurse performing this distribution, the researcher made a follow-up telephone call to each of these nurses to invite late participants.

Each questionnaire packet was marked in the upper right hand corner with job title and job numeric code. Each packet contained a signed cover letter (see Appendix C), the questionnaire, and a stamped, self-addressed envelope. Potential respondents were specifically instructed to protect their anonymity and to return the questionnaire directly to the researcher in the envelope provided. Return of a completed questionnaire constituted informed consent to participate in the study.

When completed questionnaires were received, each was given a number designation and coded for computer analysis. Incomplete questionnaires were not included in the data analysis.

Limitations

1. The sample was not randomly drawn, but delimited to those USAF mental health and nursing professionals at USAF medical treatment facilities at which all groups were represented.

2. Due to respondent anonymity, differences between respondents and non-respondents remained unknown.

3. Responses regarding role expectations held by respondents were restricted to those contained in the questionnaire, except for the comments section.

4. Findings cannot be generalized outside USAF hospital-based settings.

Summary

The purpose of this study was to describe and analyze role expectations for USAF PCNSs held by the PCNSs and their USAF professional mental health and nursing colleagues, specifically: clinical psychologists, clinical social workers, generalist mental health nurses, nurse administrators, and psychiatrists. This chapter has described the methodology of the descriptive study with correlational design devised to achieve this purpose, as well as the development of the questionnaire used to collect the data. Further, limitations inherent in the research approach used were discussed.

CHAPTER IV
ANALYSIS OF DATA

The purpose of this study was to describe and analyze role expectations for USAF PCNSs held by the PCNSs and their professional mental health and nursing colleagues, specifically: clinical psychologists, clinical social workers, generalist mental health nurses, nurse administrators, and psychiatrists. This chapter presents the data and its analysis.

First, the demographic descriptors of the sample are presented. Then, the data analysis for each of the four research questions is described. Finally, the additional comments offered by respondents are presented.

Response Rate and Demographic Characteristics of Respondents

Response Rate

The senior mental health nurses distributed questionnaire packets to 180 potential respondents. A total of 93 questionnaires were returned to the researcher, for a response rate of 51.7%. By profession, 12 of 28 clinical psychologists (42.9%), 12 of 22 clinical social workers (54.5%), 12 of 26 nurse administrators (46.2%), all 9 PCNSs (100%), 30 of 59 MHNs (50.8%), and 18 of 36 psychiatrists (50.0%) responded.

Three incomplete questionnaires, submitted by one clinical social worker, one nurse administrator, and one psychiatrist, were not included in the data analysis. Thus, the sample consisted of 90 respondents: 12 clinical psychologists; 11 clinical social workers; 11 nurse administrators; 9 PCNSs; 30 MHNs; and, 17 psychiatrists.

Demographic Characteristics of Respondents

Age of respondents

Respondents ranged in age from 23 to 69 years of age, with a mean age of 35.9 years. Nursing administrators had the highest average age (43.5 years), while mental health nurses had the lowest (33 years).

Sex of respondents

The majority of respondents (61.1%) were male. Most non-nurse respondents were male (90%), as were 40% of the nurse respondents.

Educational level of respondents

The majority of respondents (61.1%) reported either a baccalaureate or a masters degree as their highest earned degree. Approximately one-third of respondents reported a doctorate as their highest degree, including all the physicians and clinical psychologists, as well as one-third of the clinical social workers, but none of the nurses.

Non-nurse respondents reported all degrees to be in their specialty field. On the other hand, 22% of the nurse respondents reported their highest degree, either at the

baccalaureate or masters level, to be in a field other than nursing. Most nurse respondents (94.1%) reported their highest degree to be at the baccalaureate or master's level.

Professional certification of respondents

More than half (50.5%) of respondents reported certification by a state or national agency in their area of practice. Psychiatrists more often than other professionals reported certification (82.4%), and all reported the National Board of Neurology and Psychiatry to be their certifying agency. All psychologists (50%) reporting certification in a specialty area identified "other" as the applicable alternative, and none were certified by the National Board of Professional Psychology, but rather by state boards or other clinical practice specialty boards (e.g. family or neuropsychology). All nurse respondents reporting certification (30%) indicated the American Nurses' Association to be the certifying agency except for two state certified psychiatric nurses. Nurse administrators least often (8.3%) reported certification in their specialty area.

State of respondent education

Data on the states in which respondents received their professional education were collapsed into regions of the United States. Respondents were more likely to have graduated from a professional school in the North Central (23.3%) or Northeastern (22.3%) United States. Equal numbers of respondents reported graduation from a program in

the South Central and Western regions (18.9%), while the fewest number graduated in the Southeastern region (15.6%). PCNSs and MHNs were more commonly educated in the Northeastern area; other professional groups tended to have been educated in the South Central and Western regions.

Years of respondent professional practice

Reported years of respondent practice for all groups ranged from one to 34, with a mean of 8.9 years in current specialty area, and a mean of 11.7 years of total full-time practice in health care. Psychologists reported the widest range (1-34) in years of practice, while nurse administrators reported the highest group mean for both years of total practice and years in current specialty (17.8 and 15.9 years respectively). PCNSs reported the lowest mean years of practice at current specialty level (6.3 years), while MHNs reported the lowest mean total years of practice (8.3 years).

Theoretical framework for respondent practice

Eclecticism (33.1%) was the most commonly reported frame of reference for clinical practice, followed by Reality Therapy (15.3%). Respondents reporting no mental health theoretical framework for practice (8.5%) were nursing administrators (53.8%) and two of the mental health nurses.

Areas of respondent practice

More respondents (29.6%) reported practice in inpatient mental health units than other areas, followed by administration (27.4%) and adult outpatient clinics (17.8%). Clinical psychologists and social workers (33% and 22.2% respectively) more commonly reported clinical practice in adult outpatient areas, while psychiatrists evenly reported administration and adult outpatient clinical practice as their most common activity (26.8%). Both MHNs (91.2%) and PCNSs (38.5%) reported practice in inpatient mental health settings, including inpatient alcohol rehabilitation, most commonly. PCNSs also reported themselves to be involved in administration of nursing services (30.8%) and inpatient consultation (23.1%). Nursing administrators reported themselves to be involved in administration (76.9%), and also in several areas of clinical practice including alcohol rehabilitation and medical/surgical critical care areas (23.1%).

Sources of respondent information about PCNSs

The majority of respondents (81.1%) reported some knowledge of the PCNS role. This knowledge was derived from observation of, practice with, or supervision of one or more PCNSs. Other sources of information included hearing or reading about PCNSs. No source of information about PCNSs was reported by 18.9% of respondents.

The most commonly reported sources of information about PCNSs varied by group. Observation of a PCNS was the most common source of information reported by nurse administrators (63.4%), MHNs (53.3%), and psychiatrists (47.1%). Clinical psychologists' most common source of information was practice with a PCNS (50.0%). Clinical social workers most commonly reported having no source of information about PCNSs (45.5%).

Contact of respondents with USAF PCNSs

Over half (52.2%) of respondents reported their current position involved professional contact with a PCNS. Nurse administrators most commonly (66.7%) reported current professional association while clinical social workers least commonly (9.1%) did so.

A total of 67 respondents (74.4%) reported professional contact with USAF PCNSs now or at some time in the past. This figure represented 45.6% of the clinical social workers, 65.5% of the MHNs, 83.3% of the clinical psychologists and nurse administrators, and 94.1% of the psychiatrists. Of reported professional contacts, 17.3% were in departmental committee meetings, 11.7% were in clinical conferences, and 9.3% were through collaboration on staff development activities. Clinical social workers and MHNs more commonly reported working with the PCNS as a group cotherapist, while psychologists and psychiatrists more commonly reported serving as a consultant

and clinical supervisor to a PCNS. The MHNs more commonly than other groups reported having the PCNS as an administrative or clinical supervisor, while nurse administrators and psychiatrists reported more commonly than other groups that they had served as administrative supervisor to a PCNS.

Findings

This section presents the data analysis to answer the research questions. The findings are stated for each research question.

Research Question One:
What role enactment behaviors do respondents identify for the actual/perceived role of hospital-based USAF PCNSs?

A frequency distribution was constructed with responses to the actual scale of the questionnaire. Data were then collapsed. A role enactment behavior was considered to be part of the actual/perceived role of USAF PCNSs when 50% or more of the respondents indicated that they had observed it to be enacted by a USAF PCNS sometimes, usually, or always.

Findings. Respondents perceived USAF PCNSs to enact their roles through seeking psychiatric medical consultation for patient medications, conducting group therapy, serving as a professional colleague on the mental health multidisciplinary team, setting standards for inpatient mental health nursing care, and educating patients about their diagnoses and treatments. No other enactment

behaviors included on the actual scale were perceived by respondents as characteristic of the actual USAF PCNS role as enacted by PCNSs.

Research Question Two:

What role enactment behaviors do respondents identify for the ideal/expected role of hospital-based USAF PCNSs?

Responses to the ideal scale on the questionnaire were categorized in the same manner as described in the analysis for question one. Responses to the ideal position scale were similarly categorized, with a position being classified as part of the ideal/expected hospital-based USAF PCNS role when 50% or more of respondents were found to identify a PCNS in an ideal position to be potentially slightly, moderately, or very useful in contributing to the overall efficiency of the USAF health-care delivery system. Frequency of responses to the ideal and ideal position scales were then further analyzed to determine within each scale the rankings of expectations reported by respondents for the hospital-based USAF PCNS role. The results of this analysis are summarized in Appendix D.

Respondents were found to identify all but one enactment behavior on the ideal scale and all positions on the ideal position scale to be part of the ideal/expected role of the hospital-based USAF PCNS. The one behavior not identified to be characteristic of the PCNS role was, "serves as subordinate member of the mental health multidisciplinary team."

Relative frequency of expectations for enactment behaviors

Only one enactment behavior was identified by all respondents to be characteristic of the hospital-based USAF PCNS role. All respondents identified the expectation for the USAF PCNS to serve as a professional colleague on the mental health multidisciplinary team to be characteristic of the hospital-based USAF PCNS role.

A total of 19 enactment behaviors were identified by at least 79 respondents (90%), but fewer than all (100%), to be characteristic of the ideal/expected hospital-based USAF PCNS role. These 19 enactment behaviors were: performs inpatient intake interview, including mental status examination (MSE), history (HX), and current assessment; makes diagnoses in accordance with (IAW) the Manual of Nursing Diagnosis; seeks psychiatric medical consultation for patient medication; conducts group therapy; conducts family therapy; sets standards for inpatient mental health nursing care; educates patients about their diagnoses and treatments; educates families about patients' diagnoses and treatments; directly clinically supervises inpatient mental health nursing staff; acts as personal, strong patron of individual nursing staff, shaping their career growth; personally guides individual nursing staff members, pointing out pitfalls and shortcuts; bases nursing staff development program on nursing theoretical framework; bases nursing staff development program on mental health theoretical

framework; collaborates as full member of mental health consultation/liaison team for medical facility; identifies potential areas for nursing research; identifies potential areas for mental health research; develops research proposals; and, conducts and reports on nursing research.

A total of 12 additional enactment behaviors were identified by at least 72 (80%), but fewer than 79 (90%), respondents to be characteristic of the ideal/expected hospital-based USAF PCNS role. These 12 enactment behaviors were: performs outpatient intake interview, including MSE, HX, and current assessment; prescribes the mental health treatment plan for a patient; acts as primary therapist for mental health outpatients; acts as primary therapist for mental health inpatients; conducts individual psychotherapy; acts as official preceptor for new mental health nurses; directs inpatient mental health nursing staff development program; provides client-centered mental health consultation to non-mental health inpatients; provides consultee-centered mental health consultation to non-mental health staff; provides program centered mental health consultation to non-mental health departments; initiates requests for consultation from other disciplines; and, conducts and reports on mental health research.

A total of four other enactment behaviors were identified by at least 63 (70%), but fewer tnan 72 (80%),

respondents to be characteristic of the ideal/expected hospital-based USAF PCNS role. These four behaviors were: directly clinically supervises other mental health professionals; directs mental health staff development program; administratively supervises mental health nursing staff; and, conducts community case finding and screening.

A total of three more enactment behaviors were identified by at least 54 (60%), but fewer than 63 (70%), respondents to be characteristic of the ideal/expected hospital-based USAF PCNS role. These three behaviors were: makes diagnoses IAW the Diagnostic and statistical manual of mental disorders (DSM III)(American Psychiatric Association, 1980); initiates or adjusts patient medication IAW current protocols; and, administratively supervises several areas of nursing service.

One final enactment behavior was identified by at least 45 (50%), but fewer than 54 (60%), respondents to be characteristic of the ideal/expected hospital-based USAF PCNS role. The behavior of administratively supervising mental health staff was identified as part of the ideal/expected USAF PCNS role by 52 (57.78%) respondents.

Relative frequency of expectations for ideal positions

All positions listed on the ideal position scale were found to be expected by respondents to enable a hospital-based USAF PCNS to make a useful contribution to

the expectation that a PCNS on the faculty of the School of Aerospace Medicine would be useful to the overall efficiency of the USAF health care delivery system.

Findings for expectations for the ideal/expected PCNS role

Respondents identified 39 of 40 enactment behaviors listed on the ideal scale and all positions listed on the ideal position scale to be characteristic of the ideal/expected hospital-based USAF PCNS role. However, not all enactment behaviors or positions were identified to be part of the ideal/expected hospital-based USAF PCNS role with the same frequency.

Research Question Three:
What is the relationship between the actual/perceived and the ideal/expected PCNS roles reported by respondents?

Determination of the relationship between the actual/perceived and ideal/expected PCNS roles reported by respondents was accomplished by a two phase data analysis. First, the internal consistency of the actual and ideal scales was determined for the purpose of deciding which method of statistical analysis was appropriate for measuring the relationship between these two roles. Second, the relationship between the roles was analyzed with tne appropriate nonparametric correlation statistic.

Internal consistency of the actual and ideal scales was determined with the alpha coefficient procedure of the Statistical Package for the Social Sciences (SPSS; Nie et al., 1975). Using this procedure, the alpha coefficient

for the actual scale was found to be 0.97700. That for the ideal scale was found to be 0.91919. These alpha coefficients indicated that response to each item had approximately equal weight in determining overall response to each of the scales. Thus, the relationship between the actual/perceived and ideal/expected roles could be determined by measuring the correlation between the summary scores of the actual and ideal scales with the Spearman's rank order correlation coefficient, or Spearman's rho.

The relationship between the actual/perceived and ideal/expected PCNS roles reported was then measured with the Spearman's rho correlation coefficient. The coefficient of correlation was found to be 0.27141 (df = 88, p = .0097).

Findings. A weak, positive relationship (0.27141) was found between the actual/perceived and ideal/expected PCNS roles reported. The actual/perceived role was found to account for 7.37% of the variance in the ideal/expected role found.

Research Question Four:
What is the relationship between professional group and ideal/expected role reported?

Data used to answer this question were the responses to the ideal and ideal position scales. Data were coded and analyzed with the Statistical Analysis System (SAS) M-RANK procedure (SAS, 1983); the acceptable alpha level was established at .05.

Chi-squares were initially computed on data from responses to both the ideal and ideal position scales. Significant influence by profession of respondent on expectations for hospital-based USAF PCNS ideal enactment behaviors was found: X^2 (200, $\underline{N}$ = 90) = 240.4061, $\underline{p}$ = .0267. Significant influence by profession of respondent was also found on expectations for USAF PCNS ideal positions: X^2 (60, $\underline{N}$ = 90) = 81.8561, $\underline{p}$ = .0330. Chi-square tests were then performed between each professional group and every behavior and ideal position on both scales. When significance was reached on a particular behavior or position, the data were further analyzed with the M-RANK procedure to determine the source and direction of the influence. Using this procedure, expectations for 13 behaviors from the ideal scale and four positions from the ideal position scale were found to be significantly influenced by respondent professional group (see Table 4-1).

Relationship between professional group and ideal PCNS role expectations

Clinical social workers and psychiatrists were the professional groups whose mean responses to the ideal behaviors and positions were most often found to be significantly influenced. Clinical psychologists' and PCNSs' expectations were significantly influenced least often.

Table 4-1: Significant Relationships
Between Professional Group and Ideal Expectations
for Psychiatric Clinical Nurse Specialists

Enactment Behavior	Profession					
	CP[a]	CSW[b]	NA[c]	PCNS[d]	MHN[e]	MD[f]
Performs outpatient intake interview, including MSE, HX, and current assessment.		+				-
Prescribes the mental health treatment plan for a patient.		+				-
Acts as primary therapist for mental health outpatients.		+			-	-
Acts as primary therapist for mental health inpatients.		+				-
Conducts individual psychotherapy.		+				-
Conducts group therapy.		+				-
Conducts family therapy.		+			-	
Educates patients about their diagnoses and treatments.		+		-		-
Educates families about patients' diagnoses and treatments.				-		-
Acts as official preceptor for new mental health nurses.			-		+	
Provides client-centered mental health consultation to non-mental health patients.	+		+	-		-
Provides consultee-centered mental health consultation to non-mental health staff.			+			-

Table 4-1--Continued

Provides program centered mental health consultation to non-mental health departments.			-		-
Initiates requests for consultation from other disciplines.					-
Conducts and reports on mental health research.		+	-		
Administratively supervises several areas of nursing service.		-		+	+
Conducts community case finding and screening.	-	+			
Positions					
Staff nurse, mental health unit.		-		+	
Charge nurse, mental health unit.		-		+	
Supervisor, nursing service.			-	+	
Staff, nursing staff development service.			-	+	
Total expectations significantly influenced by professional group: 21					

[a]Clinical Psychologist
[b]Clinical Social Worker
[c]Nurse Administrator
[d]Psychiatric Clinical Nurse Specialist
[e]Generalist Mental Health Nurse
[f]Psychiatrist
+Professional group response significantly higher than overall mean response ($p \leq .05$).
-Professional group response significantly lower than overall mean response ($p \leq .05$).

Expectations of clinical psychologists. Clinical psychologists' mean expectations were found to be significantly higher than the overall mean response for one enactment behavior, and significantly lower for another ($p \leq .05$). Clinical psychologists rated the PCNS providing client-centered mental health consultation in non-mental health areas significantly higher, and the PCNS conducting community case finding and screening significantly lower than the overall mean expectation for these behaviors.

Expectations of clinical social workers. Clinical social workers' mean expectations were found to be significantly higher than the overall mean response for 10 enactment behaviors, lower on 1, and also lower for 2 ideal positions. ($p \leq .05$). Respondent social workers were found to have higher expectations than the overall mean response to the PCNS enacting their role through: performing outpatient intake interview, to include MSE, Hx, and current assessment; prescribing the mental health treatment plan for a patient; acting as primary therapist for in- and outpatients; conducting individual, group, and family therapy; educating patients about their diagnoses and treatments; conducting and reporting on mental health research; and, conducting community case finding and screening. The three expectations for which the social workers' mean response was found to be significantly

lower involved the PCNS administratively supervising several areas of nursing service, and enacting the PCNS role from either the inpatient mental health unit staff nurse or charge nurse positions.

Expectations of nurse administrators. The nurse administrators' mean response was found to differ significantly from the overall response mean for five expectations ($p \leq .05$). The nurse administrators were found to have significantly higher expectations for two enactment behaviors, while for two enactment behaviors and one position, significantly lower expectations. Providing client- and consultee- centered mental health consultation to non-mental health areas received higher expectational ratings from the nurse administrators. These administrators reported significantly lower expectations for PCNSs serving as official preceptor to new MHNs. Further, they expected the PCNS to be less useful in the positions of supervisor of nursing service and nursing staff development than the overall respondents.

Expectations of PCNSs. The PCNS respondents' expectations were found to differ significantly from the overall mean response for five enactment behaviors, all of which the PCNSs rated lower ($p \leq .05$). Educating patients and patients' families about patients' diagnoses and treatments were rated significantly lower by the PCNSs. The PCNSs also rated provision of client-, consultee-,

and program centered mental health consultation lower. Finally, PCNSs were found to have significantly lower expectations for the PCNS conducting and reporting on mental health research.

Expectations of MHNs. It was found that the MHNs' mean response differed significantly from the overall mean response for eight expectations ($p \leq .05$). The MHNs were found to have significantly higher expectations for two enactment behaviors and four ideal positions, and lower expectations for two enactment behaviors. The MHNs were found to have higher than group expectations for the PCNS serving as official preceptor to new mental health nurses, and administratively supervising several areas of nursing service. The MHNs' expectations were significantly higher than the overall mean response for the PCNSs enacting their role from mental health unit staff and charge nurse positions, as supervisor of nursing services, and as a member of the medical treatment facility nursing staff development service. The MHNs' expectations were significantly lower than the overall mean response for PCNSs acting as primary therapist for mental health outpatients or conducting group therapy.

Expectations of psychiatrists. Psychiatrists' mean expectations were found to be significantly higher than the overall mean expectation for 1 position, and lower for 11 enactment behaviors ($p \leq .05$). Psychiatrists were found to

have significantly higher expectations for the PCNS role being enacted from the position of administratively supervising several areas of nursing service. Psychiatrists' expectations were significantly lower for the PCNS role being enacted through: performing outpatient intake interview, including MSE, Hx, and current assessment; prescribing the mental health treatment plan for a patient; serving as primary therapist for mental health in- and outpatients; performing individual or group psychotherapy; educating patients or their families about patients' diagnoses and treatments; providing client-, consultee-, and program centered mental health consultation in non-mental areas; and, initiating consultation requests with other disciplines.

It was found that respondents' profession exerted a significant influence on expectations for the PCNS role. Clinical social workers had significantly higher mean expectations for PCNS role enactment, while psychiatrists' expectations were significantly lower, with the other professional groups' expectations situated intermediately.

Realtionships between professional group expectations and PCNS expectations

Significant differences between expectations for PCNS role enactment held by the PCNS group and those held by the other professions were also found. These finaings are summarized in Table 4-2.

Table 4-2: Significant Relationships between Professional Group Ideal PCNS Role Expectations and PCNS Group Ideal PCNS Role Expectations

Enactment Behavior	Profession				
	CP[a]	CSW[b]	NA[c]	MHN[d]	MD[e]
Prescribes the mental treatment plan for a patient.	+	+			
Acts as primary therapist for mental health outpatients	+	+			
Conducts individual psychotherapy.	+	+			
Conducts group therapy.		+			
Conducts family therapy.		+			
Educates patients about their diagnoses and treatments.	+	+	+		
Educates families about patients' diagnoses and treatments.	+	+	+		
Acts as official preceptor to new mental health nurses.				-	
Provides client-centered mental health consultation to non-mental health inpatients.	+	+	+		
Provides consultee-centered consultation to non-mental health staff.	+				
Initiates requests for consultation from other disciplines.					+
Conducts and reports on mental health research.		+	+		

Table 4-2--Continued

Conducts community case finding and screening.		+		
Position				
Staff nurse, mental health unit.		-		
Charge nurse, mental health unit.	-	-		
Staff, nursing staff development services.		-	-	
Total expectations: 16				

[a]Clinical Psychologists
[b]Clinical Social Workers
[c]Nurse Administrators
[d]Mental Health Nurses
[e]Psychiatrists
+Significantly higher than PCNS group mean ($p \leq .05$).
-Significantly lower than PCNS group mean ($p \leq .05$).

With this analysis, it was found that the mean clinical social worker response significantly differed from that of the PCNSs on 13 expectations, while clinical psychologists differed on 8 expectations, the nurse administrators on 5, and the MHNs and psychiatrists on 1. In addition, no significant differences between professional group mean responses and the PCNS mean occurred on four expectations which had been found in the analysis for professional influence in relation to overall mean response. These were: performs outpatient intake interview, including MSE, HX, and current assessment;

acts as primary therapist for mental health inpatients; administratively supervises several areas of nursing service; and, enacts the role from the position of supervisor of nursing service.

Expectations of clinical psychologists. The clinical psychologists' mean responses were significantly higher than the PCNS mean for seven enactment behaviors and lower for one position ($p \leq .05$). Respondent clinical psychologists were found to have significantly higher mean expectations than the PCNSs for PCNSs enacting their role through: prescribing the mental health treatment plan for a patient; acting as primary therapist for mental health outpatients; conducting individual therapy; educating patients and their families on diagnoses and treatments; and, providing client- and consultee-centered mental healthconsultation in non-mental health areas of the medical treatment facilities. The one expectation for which the clinical psychologists' mean response was significantly lower than the PCNS mean involved the PCNS enacting the role from inpatient mental health unit charge nurse position.

Expectations of clinical social workers. Clinical social workers' mean responses were found to be significantly higher than the PCNS mean for 10 enactment behaviors and lower for 3 ideal positions ($p \leq .05$). Respondent social workers were found to have significantly higher mean expectations than the PCNSs to

PCNSs enacting their role through: prescribing the mental health treatment plan for a patient; acting as primary therapist for mental health outpatients; conducting individual, group, and family therapy; educating patients and their families on diagnoses and treatments; providing client-centered mental health consultation in non-mental health areas; conducting and reporting on mental health research; and, conducting community case finding and screening. The three ideal positions for which the social workers' mean response was significantly lower than the PCNS mean involved the PCNS enacting the role from inpatient mental health unit staff nurse or charge nurse positions, and as staff in nursing staff development services.

Expectations of nurse administrators. The nurse administrator group's mean expectations were found to be significantly higher than the PCNSs' mean expectation for three behavior enactments, and lower for one ideal position ($p \leq .05$). Nurse administrators were found to have significantly higher expectations for PCNS role enactment than the PCNSs for educating patients and their families about the patients' diagnoses and treatments, as well as providing client-centered mental health consultation to non-mental health inpatients. This group was found to have a lower mean expectation for the PCNS enacting the role

from the position of staff, nursing staff development services.

Expectations of MHNs and psychiatrists. The MHN and psychiatrist groups were each found to differ significantly from the PCNS mean response for one expectation ($p \leq .05$). The MHNs' mean response for PCNSs functioning as official preceptor to new MHNs was found to be significantly lower than that of the PCNSs mean response. The psychiatrists' mean response was also found to differ significantly from that of the PCNSs on one expectation, that being a significantly higher expectation for the PCNS to initiate requests for consultation from other disciplines.

Findings for the relationship between professional group and ideal/expected PCNS role

It was found that profession of respondent exerted a significant influence on expectations for enactment behaviors of the PCNS role. Further, it was found that profession of respondent also influenced expectations for the ideal position from which the PCNS role could be enacted to improve the overall efficiency of the USAF health care delivery system.

Comments by Respondents

Comments were entered by 44.1% of respondents by either making entries in the comments section or by entering notes elsewhere on the questionnaire. Notes made elsewhere were transcribed by the researcher to the comments section. In general, comments centered on one of two content areas:

that is, comments about the format and phrasing of the questionnaire; and, comments offered about the role of the PCNS in the USAF.

Comments by clinical psychologists

Five clinical psychologists (41.7%) offered additional comments. Three of these five placed question marks next to, or specifically questioned, "What is the manual of nursing diagnosis?" One questioned whether a PCNS ought to initiate or adjust medications on a current protocol, and another wondered what a nursing theoretical framework was. One specified that "a PCNS 'independent' functioning as a primary provider ought to be determined by area of specialty training (child, adolescent, adult, etc.). Treatment activities [should be] also related to training." Another stated that, "the nurse practitioner in mental health is a definite asset to the care and treatment of patients and a vital part of the clinic staff. The PCNS is also an excellent liaison with the in-patient service as well as the other in-patient hospital services. There definitely should be more authorizations and personnel." This same respondent remarked that a PCNS functioning as staff or charge nurse of a mental health unit was, "a waste of expertise."

Comments by clinical social workers

Seven clinical social workers (63.8%) responded with additional comments. Three of these indicated that they had

either never worked with a PCNS or knew little about the USAF PCNS role, one noting that s/he sought out the PCNS at that facility before answering the questionnaire. One noted that past associations with PCNSs had been positive, and hoped that more would be forthcoming. Another stated that, "the individual must decide if he/she wants to be a nurse or a therapist. The responsibilities of nursing care come first." Another suggested alternative wording for 10 enactment behaviors, collapsing those relating to nursing and mental health theoretical frameworks into single behavioral statements, and wrote "if trained for it" next to enactment behaviors dealing with PCNSs adjusting medications according to a current protocol, and conducting family therapy and research.

Comments by nurse administrators

Four nurse administrators (33.3%) offered additional comments. One stated that their current position involved no PCNS contact "but could." Three stated the survey questionnaire was subjective, and that terms required more careful definition. One found behavior descriptions involving the PCNS engaging in several types of staff development and consultation confusing, "as to whether they apply to inpatients or outpatients and if other than nurses were to be included." Another reported a sense that there was no correlation between the actual and ideal scales because these would vary greatly depending on why the

PCNS was assigned to the institution. Another found the assignment of the term PCNS to anyone who had earned a clinical masters degree in nursing contradictory, stating the CNS role must be earned by a nurse regardless of academic background, and that military rank must also be considered.

Comments by psychiatric clinical nurse specialists

Five (55.6%) of the PCNSs returned additional comments with their completed questionnaires. Several noted that they answered as they themselves perform their activities since they have no professional contact with other PCNSs in their current assignment. One commented that a PCNS must be free to develop programs and research, not committed to any particular area or function within a medical treatment facility. Another noted that PCNS role enactment from the staff nurse position would be impeded by obligations to medication administration and ward coverage, while, from the unit charge nurse position, more authority and power was inherent for the PCNSs to use their expertise to institute policy changes and improve patient care. This same respondent noted that any basic, entry level nursing degree in addition to mental health experience would prepare a nurse to function as a PCNS. Another stated that tney were not permitted to use their civilian acquired expertise in making DSM-III diagnoses in the USAF, but felt no restriction of practice. Another commented there seemed to

be no current place where the PCNS will be realistically used in the USAF at this time due to reduction of allocations and restrictions placed on their practice by other health care providers. This PCNS reported experiencing little autonomy in practice and feeling his/her practice restricted by other professionals' expectations.

Comments by mental health nurses

Comments were offered by 16 (55.2%) of mental health nurse respondents. Three expressed dissatisfaction with the rating system used for the actual and ideal scales, stating that "always" was an inappropriate alternative. Two mental health nurses indicated themselves to be PCNSs even though their master's degrees were in non-nursing areas, and these indicated some frustration with not being encouraged to enact more PCNS role behaviors in the work setting. One MHN respondent indicated that two subordinates with master's in mental health nursing were assigned to ward staff nurse positions at that facility and unable to enact both staff nurse and PCNS roles. Another opined that "nursing" had allowed most positions in which the respondent envisioned a PCNS a valuable asset to be filled by other health care providers, and that PCNSs would never attain the same recognition in the USAF as "other nurse practitioners." One respondent indicated concern that an influx of master's prepared junior officers whose expectations were not commensurate with the reality of

the USAF's mission could create considerable conflict. Finally, another respondent encouraged the inclusion of primary preventative and community based enactment behaviors in the PCNS role. This MHN estimated that a review of generalist mental health nurse evaluations over the past ten years might indicate that most MHNs were considered by their supervisors to be enacting most or all of the PCNS role, as defined on the questionnaire, as generalists. This same respondent noted, "acts as strong, personal patron of individual nursing staff, shaping their career growth . . . smacks of some sort of paternal control."

Comments by psychiatrists

Three (23.5%) respondent psychiatrists offered additional comments. Two of these questioned the manual of nursing diagnosis. A third commented the questionnaire had an inflammatory tone, noted several enactment behaviors were vague, and identified that PCNSs' clinical activities must be properly supervised.

Summary

It was found that the actual/perceived role of USAF PCNS at the study medical treatment facilities was perceived by respondents to include 5 of 40 role enactment behaviors listed on the actual scale of the questionnaire. On the other hand, the ideal/expected USAF PCNS role was reported to include all but 1 of the same 40 enactment behaviors listed on the ideal scale, and all 12 enactment

positions listed on the position scale, with some variation in the strength in the expectation found. A slight, positive correlation was found between the actual/perceived and ideal/expected roles reported. A statistically significant influence was found between respondent professional group and responses to expectations for the role of the USAF PCNS listed. Clinical social workers and psychiatrists were the professional groups whose mean responses to expectations most often differed significantly from the overall group mean, while clinical psychologists differed least often. When compared to mean PCNS role expectations, clinical psychologists' and clinical social workers' expectations most often differed significantly, while MHN and psychiatrist groups differed least often.

The purpose of this study was to describe and analyze role expectations for USAF PCNSs held by the PCNSs and their professional mental health and nursing colleagues, specifically: clinical psychologists, clinical social workers, generalist mental health nurses, nurse administrators, and psychiatrists. This chapter has presented the data and its analysis. First, the demographic descriptors of the respondent sample were presented. Then, the data analysis for each of the four research questions was described. Finally, the additional comments offered by respondents were presented.

CHAPTER V
DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

The purpose of this study was to describe and analyze role expectations for USAF PCNSs held by the PCNSs and their mental health and nursing colleagues, specifically: clinical psychologists, clinical social workers, nurse administrators, generalist mental health nurses, and psychiatrists. The purpose of this chapter is to discuss the research findings derived from the data analysis, present the conclusions, and make specific recommendations for future study.

Discussion

Response Rate

The response rate for this study was 51.7%. A response rate of greater than 50% has been considered adequate in overcoming the effects of response bias for most purposes (Polit & Hungler, 1983). However, the response rate for each of the professional groups in this study varied. By profession, 100% of the PCNSs, 54.5% of the clinical social workers, and 50.8% of the MHNs responded. On the other hand, only 50.0% of the psychiatrists, 46.2% of the nurse administrators, and 42.9% of the clinical psychologists responded. The findings for the psychiatrist, nurse administrator, and clinical psychologist groups may have

been affected by response bias since their response rates were 50% or less.

Woolley (1984) has suggested several influences that may reduce questionnaire response rates and introduce response bias. Included were disliking questionnaires, feeling the questionnaire invaded ones privacy, having doubts about protection of anonymity, being disinterested in the topic, and being too busy to respond. Which of these factors were operating, and the effect nonresponse exerted on the findings, remained unknown.

Research Question One:
What role enactment behaviors do respondents identify for the actual/perceived role of hospital-based USAF PCNSs?

It was found that 5 of the 40 enactment behaviors of the actual scale were characteristic of the actual/perceived USAF PCNS role. Respondents perceived the USAF PCNS role to actually be enacted through educating patients about their diagnoses and treatments, serving as professional colleague on the mental health multidisciplinary team, conducting group therapy, seeking psychiatric medical consultation for patient medication, and setting standards for inpatient mental health nursing care. These enactment behaviors were interpreted as traditional mental health nursing behaviors also included in the role definition of the USAF generalist mental health nurse (Department of the Air Force, 1985; Peplau, 1973a). It was thus found that respondents perceived the actual role of the

hospital-based USAF PCNS to be restricted to traditional mental health nurse role enactment behaviors.

Limited PCNS role visibility may provide a possible explanation for the perception that the PCNS role was limited to traditional nursing behaviors. The PCNSs reported their practice to be limited almost exclusively to inpatient settings, with only one indicating clinical practice in an outpatient clinic. Outpatient clinics were the practice area reported most often by respondent clinical psychologists and social workers. Thus, the PCNSs' assigned area of practice may have reduced the opportunity for interprofessional contacts with clinical psychologists and social workers and influenced the perception that the hospital-based USAF PCNS role was limited to traditional mental health nursing enactment behaviors.

Practice by PCNSs on inpatient mental health units was noted by several respondents to be a factor limiting their perception of PCNS role enactment. These respondents observed that, "the responsibilities of nursing care come first," "person must decide if they want to be a nurse or a therapist," and that enactment of the PCNS role from the staff nurse position would be impeded by obligations to administer medications and provide ward coverage. Thus, it could be speculated that practice by a PCNS in inpatient mental health settings may have reduced both the visibility

and the scope of PCNS role enactment. The primary source of this confinement appeared to be institutional inertia.

Institutional inertia, with restriction of the PCNSs' work to that of the stereotype of nursing in psychiatric facilities, was predicted by the respondents to a 1955 Rutgers University study to be a potential problem in using the PCNS as educationally prepared (Peplau, 1982b). Institutional inertia in this study was perhaps reflected in the failure to differentiate between the MHN and PCNS in the officer specialty description contained in AFR 36-1, attachment 27 (Department of the Air Force, 1985). As a formal organization, the USAF does not officially recognize role differentiation between the MHN and PCNS. Institutional inertia in role definition may account for the perception that the actual/perceived hospital-based USAF PCNS role was limited to the traditional generalist mental health nursing behaviors as found in this study.

Another aspect of institutional inertia influencing perception of the USAF PCNS role might well have been the resistance of other professionals within the organization to change. The PCNS role has only been recognized in the USAF since 1977, and could be considered relatively new (Department of the Air Force, 1977). Resistance to PCNSs, and generally to clinical specialists in nursing, has been noted and mentioned by many authors since the original

conception of the role in 1943. Bird et al. (1979), DeYoung et al. (1983), Dunn (1979), Noonan (1976), Peplau (1982b), and Wondra (1974) have all mentioned the resistance of psychologists, psychiatrists, and social workers to expanding the practice role of the nurse in mental health and other health care areas. Fleming & Davis (1980), Peplau (1982b), and Wondra (1974) found that generalist mental health nurses were resistant to institution of advanced nursing practice by PCNSs in the form of practicing psychotherapy. Christman (1973a), DelBueno (1976), and Peplau (1982b), among others, have addressed the resistance of nursing administrators to a purely clinical CNS role. Thus, past resistance by other professional groups to PCNS role implementation may have been a factor influencing the perception that the PCNS role was in fact restricted to traditional generalist mental health nurse enactment behaviors through the influence of this past resistence on the current institutional role sending.

Restriction of the perceived PCNS role to generalist mental health nurse role enactment behaviors may present PCNSs with role conflict. This conflict was seen to be between the institutional role sending and the PCNSs' professionally acquired expectations. PCNSs have been educated to enact most behaviors listed on the actual scale. These behaviors represented the professionally acquired expectations of the PCNSs. PCNSs would then expect

to enact these behaviors in the practice setting. The respondents' perception was, however, that the actual PCNS role included a very limited selection of possible enactment behaviors.

It has been emphasized that the greater the degree of organizational formalization in rules and regulations, the greater the likelihood that professionals will experience conflict between their professionally acquired role expectations and the expectations for their role performance communicated by the organizational role set (Green, 1978). Military health care settings have been identified as highly formalized (Boydstun & Perry, 1980). This highly formalized setting, with its highly formalized institutional role sending, may present PCNSs with role conflict through this actual/perceived hospital-based USAF PCNS role.

Comments by PCNSs would seem to indicate they do experience this conflict, both from placement in medical treatment facility positions and perceived restrictions on their practice. Several MHN respondents also perceived conflict in the PCNS role, remarking that PCNS qualified nurses placed in staff nurse positions were unable to enact PCNS role behaviors, that potential PCNS positions were occupied by members of other professions, and that PCNSs would never be accorded the same recognition as "other nurse practitioners." While all PCNSs did not remark on

perceived conflict, the undifferentiated specialty description, the restricted perception of actual enactment behaviors reported by respondents, and the comments offered, suggested its presence.

Focal role occupants who experience role conflict have been reported to be less effective. Not only may the focal role occupants function less effectively, but also if they encounter sufficient conflict will tend to leave the organization, thereby increasing costs to replace personnel (Green, 1978; Katz & Kahn, 1978). If USAF PCNSs continue to perceive role conflict, the talent and expertise the PCNSs have acquired in training and experience may not fully benefit the USAF health care delivery system. First, the talents and expertise of the PCNSs may not be fully used. Second, as result of PCNS dissatisfaction, increased PCNS turnover, with increased personnel costs, may result.

A negative bias to the findings was suspected, and several possible sources for this potential bias were identified. First, one quarter of the respondents reported no contact with USAF PCNSs and selected the "Never" alternative on the actual scale. These responses may have weighted the frequency distribution towards this direction. Second, while 52.8% of the respondents reported contact with USAF PCNSs, the most frequent contact was in departmental committee meetings, followed by patient-centered case conferences. Neither committee

meetings nor case conferences provided a basis for perception of most PCNS enactment behaviors listed on the questionnaire. Third, 25% of respondents reported past, but not current, USAF PCNS contact and thus were in the position of having to remember what behaviors the PCNSs had enacted. Faulty respondent memory has been cited as a source of response errors in questionnaires (Woolley, 1984). Because of these possible sources of bias, the findings were treated cautiously.

The statistical analysis plan for this study did not include separately treating questionnaires from those respondents who reported only these three types of professional contact with USAF PCNSs. The nature of the effect respondents reporting only these types of professional contact with a PCNS exerted on the findings remained unknown. A significant negative bias was considered to be possible. Any future replications of this study should include separate analysis of responses from subjects with no PCNS contact. Such a measure may both determine the effect no respondent professional contact with PCNSs would have on the perception of the PCNS role, and eliminate this potential bias from the study.

It was concluded that the actual/perceived hospital-based USAF PCNS role was restricted to the traditional mental health nursing enactments of educating patients about their diagnoses and treatments, serving as a

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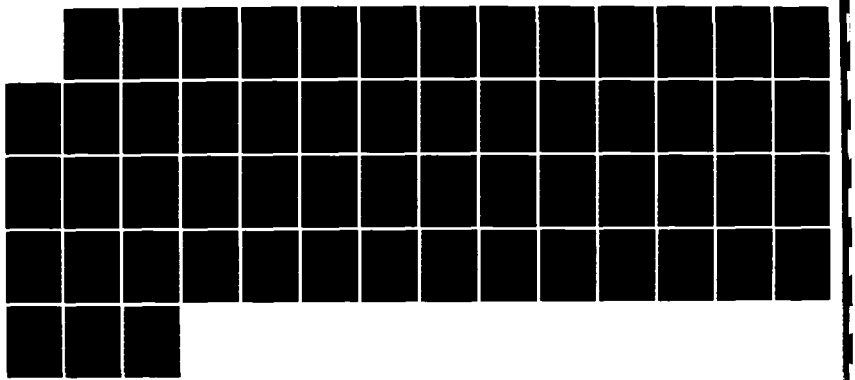

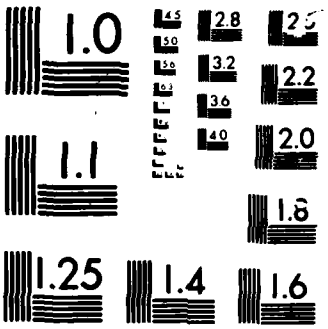
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professional colleague on the mental health multidisciplinary team, conducting group therapy, seeking psychiatric medical consultation for patient medications, and setting standards for inpatient mental health nursing care. This actual/perceived role may place the USAF hospital-based PCNS at risk for role conflict. The primary source of this conflict was seen to be between professionally acquired goals and the formal institutional role sending contained in AFR 36-1, Officer specialties, which set the institutional goals for the role occupant, the hospital-based PCNS. This role conflict may lead to decreased effectiveness of USAF PCNSs, failure of the USAF health care delivery system to fully benefit from the PCNSs' skills, and increased personnel costs from higher PCNS turnover.

Recognition of this actual/perceived PCNS role position may enable the USAF hospital-based PCNSs to cope more effectively with their current role position, and be in a better position to make changes in how the role is formally defined. However, in formal organizations, role change by the focal person is often difficult, and requires support of formal, organizational leaders. Formal, successful change to the hospital-based USAF PCNS role therefore will require support of USAF mental health and nursing leaders. Of particular organizational concern may be the formal organizational role sending contained in AFR 36-1,

Officer specialties (Department of the Air Force, 1985). This formal organizational role sending does not differentiate the USAF PCNS role from that of the USAF MHN and does not implement the NLN's 1956 recommendation to do so (NLN, 1973a).

Research Question Two:
What role enactment behaviors do respondents identify for the ideal/expected USAF PCNS role?

All enactment behaviors listed on the ideal scale except, "serves as subordinate member on mental health multidisciplinary team," were found to be characteristic of the ideal/expected hospital-based USAF PCNS role. Further, all positions listed on the ideal position scale were found to be included in the ideal/expected role.

With regard to expectations for enactment behaviors for the hospital-based USAF PCNS role, three trends were apparent:

1. Expectations for traditional mental health nursing enactment behaviors tended to rank higher than those for non-traditional mental health nursing behaviors.

2. Expectations for enactment of a behavior tended to rank higher when it was related to nursing or to nursing staff than if the same behavior were related to mental health.

3. Expectations for educator enactment behaviors ranked highest. Expectations for researcher enactment behaviors ranked next, followed by consultant/change agent,

practitioner, and administrator enactment behaviors respectively.

The three positions for which expectations ranked highest were: staff on a mental health consultation team; staff in an adult outpatient mental health clinic; and, charge nurse on a mental health unit. With regard to expectations for the usefulness of a PCNS in contributing to the overall efficiency of the USAF health care delivery system, the following trends were apparent:

1. Within nursing service, expectations for positions with administrative authority ranked higher than expectations for those without such authority.

2. Expectations for staff positions outside of nursing service ranked higher than expectations for any position within nursing service that lacked administrative authority.

3. Expectations for the faculty position at the School of Health Care Sciences ranked higher than those for any staff position in nursing service.

The change in response profile from that found for the actual/perceived role to that found for the ideal/expected role may have represented a step towards organizational evolution for the USAF PCNS role. The three trends noted for enactment behavior expectations could be seen to support this speculation that PCNS role evolution was occurring. All behaviors of the actual/perceived role were found to rank high in the expectations for the

ideal/expected role. Further, the first and second trends noted above suggested that respondents, while still more comfortable with PCNSs enacting nursing behaviors, were admitting generic mental health behaviors to expectations for the ideal/expected hospital-based USAF PCNS role. The trends noted for position expectations further supported this interpretation. These three trends clearly outlined an expectation that maximum usefulness of the PCNS to USAF health care delivery would occur at the boundary between mental health and nursing services, on the mental health consultation/liaison team. Further, the trends appeared to be in the direction that a PCNS would be more useful to USAF health care delivery more mental health department positions than from nursing service positions, unless these nursing service positions were those with administrative authority. As one PCNS commented, administrative authority within nursing service would enable the PCNSs to use their expertise in instituting policy changes and improving patient care. Perhaps respondents viewed these alternative positions as a means of maximizing the positive influence of the PCNS on USAF health care delivery. Or, perhaps respondents in general perceived that the PCNS role within nursing service could be more effectively implemented if administrative authority for the PCNS supplemented their expert authority as nurses with advance practice skills as did this one PCNS respondent.

The ideal/expected PCNS role was found to be a boundary role. This boundary role position was consistent with that reported by Gaines (1981). As a boundary role, the USAF PCNS hospital-based role was found to contain multiple possible sources for role conflict. The role described was found to include 39 different behaviors, and was involved in several systems of the hospital-based setting. Not only was the ideal/expected role found to involve behaviors in several areas of both the inpatient and outpatient mental health and nursing services, but also to involve behaviors with other professional services through consultation/liaison activities. Multiple subsystem involvements while engaging in multiple enactment behaviors by one person could be seen to lead to role strain and conflict. The role strain and conflict inherent in a boundary role can lead to degradation of the efficiency of both the PCNSs and professional members of the PCNSs' role set if the PCNSs do not anticipate the strain and take active measures to prevent and control it (Katz & Kahn, 1978). Therefore, USAF hospital-based PCNSs should proceed with caution in defining their role to others, and engage in pro-active role definition of their role with others to lessen boundary role strain.

Another possible source of conflict in enacting the ideal/expected PCNS role was found in the differences between the ideal/expected role and the PCNS specialty

description contained in AFR 36-1, atch 27, Officer specialties (Department of the Air Force, 1985). Enactment of the ideal expectations would represent a specific expansion of the role behaviors outlined in the regulation. Further, positions from which the role would be enacted would be specified. Such enactment, at a time before official change to the regulation that officially recognized the PCNS ideal/expected role, might lead to increased conflict with those members of the role set not prepared to accord the PCNSs with these expectations until official change is made to the regulation. At a time of role change a greater need for administrative support of PCNSs by nurse administrators has been documented (Brown, 1983a; Christman, 1973a; Peplau, 1982b; Sample, 1983). The USAF PCNSs should seek the support of these leaders in USAF mental health and nursing services if the ideal/expected USAF PCNS role found in this study were to be implemented and more effective use of the PCNS in USAF hospital-based settings were to result.

These findings were treated cautiously. Woolley (1984) and Polit and Hungler (1983) have both mentioned factors in response to questionnaires that may introduce bias. These included the desire to appear in a positive light, and respondent guessing. These two factors were considered to be influential since 18.8% of respondents indicated they had no source of information about the PCNS role, and 25.6% have had no direct experience with a practicing USAF PCNS.

One respondent stated that more information about PCNSs would have made a difference in his/her responses. Another admitted, in the comments section, to making "educated guesses." Thus, the validity of these findings was considered to be questionable, and the findings were treated with caution.

The analysis design for this study did not include treating separately questionnaires from respondents reporting no knowledge of, or contact with, PCNSs. Future replications of this study should include such a measure to control for, and detect the influence of, these factors on the data.

It was concluded that professional role set members were willing to accord PCNSs with expectations for role enactment consistent with their training and expertise and consistent with reported expectations in the nursing literature. However, this ideal/expected role was found to be in conflict with both the actual/perceived hospital-based USAF PCNS role and the official role sending contained in AFR 36-1. The USAF PCNS role is still fairly new. Perhaps further role change will eventually lead to full evolution of the USAF hospital-based PCNS role to the ideal/expected role found in this study. Further role evolution may increase the value of the PCNS to the overall efficiency of the USAF health care delivery system by fully

utilizing the skills in which the PCNSs are educationally prepared.

Research Question Three:
What is the relationship between the actual/perceived and ideal/expected role of the hospital-based USAF PCNS?

A low positive correlation (0.27141) was found between the PCNS role as respondents perceived the role to be enacted and respondent expectations for PCNS role enactment under ideal circumstances. The actual/perceived role was found to account for 7.37% of the variation in the ideal/expected role. Thus, some factor(s) other than perception of role enactment appeared to be influencing responses to the ideal scale for expectations (Hinkle et al., 1975).

Expectations for role occupants' role enactment behaviors have been found to result from complex interactions between members of the role set and the focal role occupants (Katz & Kahn, 1978). In this study, the role set members were the non-PCNS respondents while the focal role occupants were the PCNSs. Additionally, several factors have been identified as influential on expectations for PCNS role enactment. These have included: the goals and services of the practice setting; the professional orientation and experience level of the nursing staff; the care requirements of the patients served; pre-existing expectations acquired in professional education; and, expectations of non-nurses in the

practice setting (Blount et al., 1979; Brown, 1983a; Cooper, 1973; Crabtree, 1979; Edlund & Hodges, 1983; Gaines, 1981; Fife, 1983; Fife & Lemler, 1983; Girouard & Spross, 1983; Noonan, 1976; Wondra, 1974). Role expectations for members on the mental health team have also been found to be influenced by the perception of the members' potential supportiveness and degree of threat to the perceiving professionals' status and influence on the team (Zander et al., 1957).

It was speculated that the role sending process, between the PCNSs and the non-PCNS respondents, was influential in the change of responses between the actual and ideal scales. Non-PCNSs may have observed the PCNSs to successfully enact the actual/perceived role, and have developed a sense of trust in the PCNSs' expertise for enactment of the behaviors involved. This trust in the PCNSs' expertise thus may have lead to evolution of expectations for the PCNS role from those perceived as part of the actual/perceived role to those of the ideal/expected role. Thus, it could be speculated that the role sending process has been active between hospital-based USAF PCNSs and represents a source of unexplained variance between the actual/perceived and ideal/expected roles identified.

In a similar fashion, it could be speculated that respondents perceived the goals and services of the setting and the patients' care requirements to be less well met by a

PCNS enacting the actual/perceived role than through one enacting the ideal/expected role. This would be consistent with the expectation expressed in the nursing literature that the purpose of a PCNS on a hospital-based nursing staff is to improve patient care and the quality of nursing practice (Christman, 1973a; DeYoung et al., 1983; NLN, 1973b; Reiter, 1973). Respondents could thus be seen to define their expectations for the ideal/expected hospital-based USAF PCNS role in terms of improvement of nursing practice and patient care. The emphasis on educator, researcher, and consultant expectations found in the ideal/expected role supported this speculation. Respondents may have perceived they were defining a role for the hospital-based USAF PCNS to have maximum influence on other practitioners and patients through broad-based behaviors rather than restricting the role to the clinical practice sphere. Experience of PCNS role enactment in a particular setting has been found to influence expectations for the PCNS role (Blount et al., 1979; Brown, 1983a; Cooper, 1973; Crabtree, 1979; Edlund & Hodges, 1983; Gaines, 1981; Fife, 1983; Fife & Lemler, 1983; Girouard & Spross, 1983; Noonan, 1976; Wondra, 1974).

Further, expectations for PCNS role enactment may have been influenced by previous professional education. This education may have interacted with experience to modify expectations. Since most non-nurse respondents were

educated in the Western and South Central areas, identified by Ropka and Faye (1984) to contain a high concentration of PCNSs, previous exposure to PCNSs in the course of professional education was considered likely. This experience may have influenced respondents' expectations apart from the experience in the USAF practice environment. Similarly, nurse respondents would have been exposed to nursing expectations for CNS and PCNS role enactment in the course of their educational experience. These expectations are now included in standard nursing texts (Haber et al., 1982; Wilson & Kneisl, 1983).

One further factor may have accounted for the low degree of correlation between the actual/perceived and ideal/expected hospital-based USAF PCNS roles found. Zander et al. (1957) found that if a new professional group was perceived to be supportive of psychiatrists', clinical psychologists', and clinical social workers' own professional goals, and not a threat to their status, the new group might be accorded higher expectations than if a threat or a potential conflict were perceived. Clear role sendings by PCNSs, coupled with professional educational and setting-specific experience of PCNS role enactment, may have communicated both a high degree of supportiveness and a low degree of threat or potential conflict from the PCNSs towards respondents.

The construction of the questionnaire made measurement of the relationship between actual and ideal PCNS role positions impossible. Information on actual PCNS role positions was not gathered. A future revision of the questionnaire might adapt a parallel format for actual and ideal usefulness of the PCNS in various role positions similar to that used for the enactment behaviors of the actual and ideal scales. Such a construction would have enabled measurement of the relationship and is recommended.

It was concluded that the actual/perceived hospital-based USAF PCNS role exerted a slight positive influence on expectations for the ideal/expected hospital-based USAF PCNS role. Other factors possibly contributing to the expectations for hospital-based USAF PCNSs may well have included pro-active role sending by the PCNSs, professional education and experience, and recognition by respondents, based on their experience of the USAF health care environment, that the quality of nursing practice and patient care would benefit from a nurse enacting the ideal/expected PCNS role in USAF health care settings.

Research Question Four:
What is the relationship between respondent profession and ideal/expected role reported?

Expectations for 13 enactment behaviors from the ideal scale and 4 positions from the position scale were found to

be significantly influenced by respondent professional group. However, when the mean PCNS response was used as the reference point, the pattern and number of significant influence by professional group expectations changed.

Expectations of clinical psychologists

Clinical psychologists were found to have expectations for the hospital-based USAF PCNS that were generally consistent with the overall mean response. Significant influence appeared in their higher expectation for PCNSs performing inpatient client-centered consultation, and lower expectations for PCNSs conducting community case finding and screening. When compared to the PCNS mean response, clinical psychologists were found to have significantly higher expectations for three practitioner, two educator, and two consultant/change agent role enactments. These were: prescribes the mental health treatment plan for a patient; acts as primary therapist for mental health outpatients; conducts individual psychotherapy; educates patients about their diagnoses and treatments; educates families about patients' diagnoses and treatments; provides client-centered mental health consultation to non-mental health inpatients; and, provides consultee-centered mental health consultation to non-mental health staff. The only clinical psychologist expectation found to be significantly lower than the typical PCNS response was

enactment of the PCNS role from the mental health inpatient unit charge nurse position.

More than half of the respondent clinical psychologists indicated both direct observation of, and clinical practice with, PCNSs as their sources of information about them. Further, respondent clinical psychologists had also provided PCNSs with clinical supervision and consultation. Only two reported no previous contact with PCNSs in USAF hospital-based settings. As a group, the respondent clinical psychologists reported a credible degree of familiarity with USAF PCNSs and their role.

The response pattern of the psychologists in this study was found to be different than that reported for other studies in the literature. Wondra (1974) found that males with doctorates tended to define the PCNS role more narrowly. Bird et al. (1979) and DeYoung et al. (1983) both identified clinical psychologists as severely opposed to PCNSs engaging in the role for which they were educated, and expressing the expectation that PCNSs should restrict their practice to traditional mental health nursing behaviors or practice as public health nurses. By contrast, psychologists responding to this study, when their expectations differed significantly from those of the remainder of respondents, tended to be higher except for the PCNS conducting community case finding and screening. In fact, psychologists' expectations for the several PCNS

enactment behaviors noted above were significantly higher than the PCNSs' own expectations. Important to note here were the higher expectations for prescribing the patient's mental health treatment plan, practicing individual psychotherapy, and providing consultee- and client-centered mental health consultation. These behaviors were felt to connote a general expectation for advanced PCNS practitioner enactment behaviors higher than nurse or psychiatrist respondents.

In general, clinical psychologists' expectations were consistent with the overall expectations found for the ideal/expected role for the hospital-based USAF PCNS. As stated above, then, these clinical psychologists identified a PCNS role that would have maximum impact on the improvement of the quality of nursing practice and the care of the patient. They appeared, however, to be placing a significantly higher emphasis on practitioner enactment behaviors than the overall mean response. Given their experience with PCNSs in practice and supervision, and their experience with outpatient practice and inpatient consultation, they may have been aware of specific enactments of the PCNS role that could make better use of the PCNSs' expertise.

Clinical psychologists' comments support this speculation. Their comments reflect the expectation that the PCNSs have definite assets to offer the mental health

team in performing liaison services with non-mental health areas as well as a psychotherapist, one even specifying the staff nurse position on an inpatient mental health service to be "a waste of expertise."

Psychologists were found to have one significantly lower expectation for PCNS role enactment: Conducts community case finding and screening. This one area was exclusively reported by clinical psychologists. It could not be determined whether they based this expectation on actual knowledge of the PCNSs with whom they had had contact or if this represents some form of professional territoriality.

Clinical psychologists were the group with the lowest response rate. Therefore, they would be the group for which nonresponse bias would be the most probable, and these findings must be treated with caution.

Expectations of clinical social workers

Clinical social workers expectations were markedly higher for almost every enactment behavior for which significant professional group influence was found. At the same time, the clinical social workers were the group reporting the least knowledge of, or professional contact with, USAF PCNSs. This last condition was felt to render their expectations the most suspect.

It could be speculated that, in the interest of providing the researcher with positive results, the

social workers "guessed," as one reported doing. Clinical social worker expectations were consistently significantly higher for practitioner and consultant behavior enactment, and lower for traditional nursing positions of staff nurse, charge nurse, and nursing supervisor.

Findings for the expectations held by social workers for the PCNS role were at variance with those reported by Noonan (1976), Wondra (1974), and DeYoung et al. (1983). Each of these studies reported clinical social worker expectations for the PCNS role that were lower than the PCNSs' own expectations.

This study's findings were, however, more consistent with those reported by Mullaney et al. (1974). Mullaney et al. found that social workers in hospital-based settings were interested in expanding professional collaboration with PCNSs. Social workers in Mullaney's study were found to express positive expectations for PCNSs enacting their role through clinical supervision of nursing staff, and through supportive psychotherapeutic and nursing staff development activities. Social workers responding to this study were not only found to express positive expectations for enactment of the ideal/expected hospital-based USAF PCNS role, but also to have significantly higher expectations for this role than the PCNSs themselves.

The findings of this study may have reflected the clinical social workers' lack of experience with USAF PCNSs. They may have perceived the description of a master's prepared clinical nurse as being similar in education as a master's prepared social worker, and reported their expectations for the PCNS based on their perception of their own role. On the other hand, expectations of those with more valid knowledge and experience with USAF PCNSs may have reflected the previously mentioned speculations about role evolution process in their expectations. Having observed USAF PCNSs enact successfully those aspects of the actual/perceived role reported, they may have based their higher expectations on these successful enactments. These role sendings from the PCNSs may have resulted in the social workers' expectation that a broader, less restricted PCNS role was indicated.

With fewer than half of the clinical social worker respondents reporting actual practice with and information about the PCNS role, findings on their expectations were the most suspect of those for any professional group. Isolation, and separate treatment, of responses from clinical social workers would have been particularly informative. Information on the influence of direct PCNS contact for social workers' expectations, and whether the expectations were significantly related to contact or non-contact, would have been most helpful. As

noted previously, such a measure should be included in any future replications of this study.

Expectations of nurse administrators

Nurse administrators' responses indicated a higher than the typical group expectation for the PCNS providing consultation services, with significantly lower expectations for the PCNS as preceptor for new mental health nurses, and PCNSs enacting their role from a nurse administrator or staff development position. In comparison to the PCNS reference mean, nurse administrators had higher expectations for: educates patients about their diagnoses and treatments; educates families about patients' diagnoses and treatments; provides client-centered mental health consultation to non-mental health inpatients; conducts and reports on mental health research; and, conducts community case finding and screening. Nurse administrators were found to have lower expectations for the PCNS as a nursing service staff development staff member. For the majority of behavioral enactments and positions, nurse administrators' expectations were found to be consistent with the overall mean response and the PCNSs' mean response for enactment behaviors and positions.

Nurse administrators were somewhat traditional in their expectations. Demographically, they were the group with the highest average age, longest mean years of practice, and longest average length of time in their area of

specialization. Over two-thirds of nurse administrators reported professional contact with a USAF PCNS.

Nurse administrators' expectations were in agreement with those of Baker and Kramer (1970), who suggested that nurse administrators valued the consultant/change agent role above all others. They did not reflect the current concern in the nursing administration literature for placement of the PCNS in an administrative position (Butts, 1974; DelBueno, 1976). Further, the nurse administrators' expectations did not reflect the findings of several others that nurse administrators most highly value PCNS involvement in direct patient care (Clifford, 1981; Dudley, 1982; McVay et al., 1973). The nurse administrators' expectations were consistent with Ropka and Fay's (1984) report that consultant/change agent and educator behavioral enactments were more highly valued by nurse administrators.

Nurse administrators were found to be in general agreement with other respondents on expectations for the hospital-based USAF PCNS role. This agreement may be important to the PCNSs in as much as nurse administrators might be the nursing leaders upon whom the PCNSs must primarily rely for support in formal redefinition of their role in the USAF. The importance of nurse administrator support for PCNS role definition has been emphasized repeatedly in the literature.

While nurse administrators' expectations were found to be in general agreement with those of other respondents, one caution in interpreting findings on their expectations was found to be important. Only 46.2% of nurse administrators responded to the questionnaire. Therefore, the possibility of response bias must be considered in the findings for this group's expectations.

Expectations of MHNs

Similarly, the MHNs were in general agreement with the overall group response and that of the PCNSs. However, their mean response to two practitioner enactments was lower than the overall group mean: acts as primary therapist for mental health outpatients; and, conducts family therapy. MHNs also reported higher mean expectations for the PCNS as preceptor, nurse administrator, and as staff or charge nurse on mental health inpatient unit as well as a member of the nursing staff development team. When compared to the PCNS mean response, MHNs differed significantly on only one item, reporting lower expectations for the PCNS as preceptor of new mental health nurses.

The MHNs reported the lowest average years of practice, and were the youngest group. The MHNs also reported more consistent contact with PCNSs through clinical supervision and clinical practice, as well as administrative supervision.

Expectations held by MHNs showed consistent emphasis for the PCNS to be an administrative as well as clinical leader. Their expectations seemed to emphasize that the PCNS practice in an inpatient unit level position and provide the MHNs with administrative leadership and staff development guidance. This was found to be consistent with Dunn's (1979) findings that staff nurses tended to look upon the clinical nurse specialist as a nursing resource for themselves. As previously mentioned, MHN's comments reflected the perception that the PCNS role was conflict ridden in the USAF hospital-based setting.

Of particular interest was the finding that the MHNs' expectations for PCNS role enactment differed significantly from those of the PCNSs for only one behavior. Fewer than 50% of the MHNs acknowledged professional contact with a USAF PCNS, therefore exposure to PCNS role expectations through professional education and experience in the hospital-based setting may be the major influences on expectations for the role. This group, then, may be one with whom common expectations for PCNS role enactment exist. Further, if the role were enacted according to the expectations found, this group would be the one receiving much of the PCNSs' educational and research assistance. Since the expectations of the two groups were found to be so close, the relationship between them as PCNSs begin enacting new behaviors not contained in the

actual/perceived PCNS role would begin on common ground, and lead to a decrease in perceived conflict in the PCNS role.

Expectations of PCNSs

Significant influence by professional group appeared in expectations by PCNSs for their own role enactment. This influence was found only for a limited number of behaviors, and PCNSs' expectations were always lower when significantly influenced. In relationship to other groups, PCNSs' expectations were found to vary least from those of mental health nurses and psychiatrists, and in a limited way from those of nurse administrators. Only in relationship to expectations of clinical psychologists and social workers were large numbers of significantly influenced expectations for enactment behaviors found. For these last two professional groups, most expectations for the PCNS role were significantly higher than those held by the PCNSs. This pattern of relationships between expectations for the ideal/expected role was seen to further support the speculation that role sending between the PCNSs and members of their role set has been active and accurate.

The primary implication for PCNSs appeared to be that with nurse administrators, MHNs, and psychiatrists the PCNSs shared common expectations for their role enactment. Despite the degree of apparent conflict in the current PCNS role position and in the ideal/expected PCNS role found cited previously, sharing common expectations with

professional groups with whom the PCNSs could expect to be most involved would indicate that enactment of the ideal/expected role, a changed role from that actual/perceived, might proceed more smoothly. Further, that two of these groups, the nurse administrators and psychiatrists, would be those most involved in officially sanctioning recognition of the ideal/expected hospital-based USAF PCNS role seemed to indicate that the ideal/expected PCNS role would earn the administrative support required for role change in a formal organization.

Findings included that PCNS expectations for their role enactment tended to be significantly lower than those of other groups when significant relationships appeared. PCNSs might well be aware of the dangers inherent in attempting to enact too complex a role. PCNSs tended to avoid selecting the "Always" alternative on the ideal scale, choosing instead "Sometimes" and "Usually." PCNSs were thus seen to be anticipating role conflict, and taking measures to control it even in their responses to the questionnaire.

Expectations of psychiatrists

Psychiatrists' expectations for ideal/expected role enactment behaviors indicated a significantly lower expectation for all practitioner, educator, and consultant/change agent enactment behaviors on which significant differences occurred. However, they reported

significantly higher expectations for one administrative role enactment behavior: administratively supervises several areas of nursing service. In comparison to the typical PCNS expectations for enactment behaviors and positions, no significant differences in expectations were found.

While psychiatrists' expectations as reported allowed for all PCNS enactment behaviors they were consistently lower than that reported by others, perhaps more cautious. These findings are consistent with the findings of previous researchers in other settings. Davidson et al. (1978), Wondra (1974), Dunn (1979), and DeYoung et al. (1983) all reported similar findings concerning psychiatrist expectations for PCNS role enactment. Zander et al. (1957) and DeYoung et al. (1983) commented that psychiatrists tended to maintain control over other mental health professionals. Psychiatrists were noted to maintain this control by defining the others' roles as designed to assist the psychiatrist, resisting change in the roles of others, and by minimizing others' competence. While these last two observations could not be inferred from the results of this study, psychiatrist comments did tend to focus on ensuring that the PCNSs enacting clinical behaviors received proper supervision for these activities.

While psychiatrists' expectations were found to be the most conservative of any group, they were found to be

similar to those held by the PCNSs. More than 90% of the psychiatrists reported direct professional contact with USAF PCNSs, including practice with, and clinical and administrative supervision of PCNSs. At the same time, the psychiatrists reported the lowest average years of practice in specialty, and the highest certification rate. These respondents were thus seen to be highly identified with their profession and its values. Thus, while they did concur with the overall group expectations for the ideal/expected hospital-based USAF PCNS role, their profession's influence on their expectations was found to be strong and pervasive in their expectations.

Conclusions

The hospital-based PCNS role in the USAF was found to be subject to conflict, both between expectations held by professional members of the role set and the officially prescribed role outlined in AFR 36-1, Officer Specialties, between the actual/perceived role and the ideal/expected role, and by differing expectations for the ideal/expected role held by different professional groups. The actual/perceived role for the USAF PCNS in hospital-based settings was found to consist of five behavioral enactments derived from the traditional mental health nurse generalist role and represent an under-utilization of PCNS expertise. The ideal/expected role for the USAF PCNS in hospital-based settings was found

to consist of the majority of listed enactment behaviors, including all behaviors reported in the current nursing literature. Highest expectations for the ideal/expected role were for educator enactment behaviors, followed by researcher, consultant, practitioner, and administrative enactment behaviors respectively. A weak, positive relationship was found between the actual/perceived and the ideal/expected hospital-based PCNS role in the USAF. A statistically significant relationship was found between respondent professional group and ideal/expected role reported.

Recommendations for Future Study

1. The questionnaire should be tested for validity and reliability in the United States Air Force hospital-based setting. Further refinement of the demographic portion of the questionnaire should be included in this process to clarify instructions, and eliminate multiple choice alternatives. The position scale should be modified to follow a paired Likert-type format similar to that used for the actual and ideal scales, and thus allow comparison between the PCNSs' usefulness in actual and ideal positions. Further, enactment behaviors should be randomized and include more negatively scaled items to eliminate the possibility of response set bias.

2. An interview schedule should be constructed to be used along with any further testing with this

questionnaire. This schedule would concurrently gather more in-depth information on PCNS role expectations, and specifically address PCNS expectations for their own role.

3. This study should be repeated, with the refined instrument, using a random sample of USAF nursing and mental health professionals drawn from USAF hospital-based settings to more carefully define the ideal/expected hospital-based USAF PCNS role and analyze for influences in response to PCNS ideal expectations beyond the scope of this study.

4. The results of this later study should be coupled with a USAF manpower study to determine where, in addition to the present locations, PCNSs enacting the ideal/expected role described in this study should be placed to improve patient care and the quality of nursing practice cost-effectively.

5. Other studies, using questionnaires and designs modeled after those of this study, might be performed to assess expectations for clinical nurse specialists in other specialty practice areas and determine where in the USAF health care delivery system these other types of clinical nurse specialists should be placed to best improve the quality of patient care and nursing practice.

6. After further reliability and validity testing, and modification as suggested above, this study might be repeated in another setting to determine the extent to which

specific changes in setting affect expectations for PCNS role enactment behaviors.

Summary

The purpose of this study was to describe and analyze role expectations for USAF psychiatric clinical nurse specialists held by the PCNSs themselves and by their mental health and nursing colleagues, specifically: clinical psychologists, clinical social workers, generalist mental health nurses, nurse administrators, and psychiatrists.

The hospital-based PCNS role in the USAF was found to be subject to much conflict, both between expectations held by professional members of the role set and the officially prescribed role outlined in AFR 36-1, atch 27, between the actual/perceived role as it is enacted and the ideal/expected role as reported by respondents, and by differing expectations for the ideal/expected role held by different professional groups of the role set. The actual/perceived role for the USAF PCNS in hospital-based settings reported by respondents was found to be derived from the traditional mental health nurse generalist role. The ideal/expected role for the USAF PCNS in hospital-based settings as reported by respondents was found to consist of the majority of listed enactment behaviors which included all behaviors reported in the current nursing literature. Highest expectations were found for educator

enactment behaviors, followed by expectations for researcher, consultant, practitioner, and administrative enactment behaviors respectively. A weak, positive correlation was found between the actual/perceived and the ideal/expected hospital-based PCNS role in the USAF. A statistically s gnificant relationship was found between respondent professional group and ideal/expected role reported.

APPENDIX A
SURVEY OF ROLE EXPECTATIONS FOR UNITED STATES AIR FORCE PSYCHIATRIC CLINICAL NURSE SPECIALISTS

PART A: This section collects demographic data that will be used to describe the study respondents. Please answer each question as it describes you by placing an (X) in the space provided, and specify additional information when indicated. Please remember that, for the purpose of this study, a Psychiatric Clinical Nurse Specialist (PCNS) is a mental health nurse with a master's degree in nursing and a major in clinical practice.

1. Professional group you belong to:
   (_) Clinical Psychologist (AFSC 9181 or 9186, or -B)
   (_) Clinical Social Worker (AFSC 9191 or 9196)
   (_) Nurse Administrator (AFSC 9711 or 9716)
   (_) Psychiatric Clinical Nurse Specialist (AFSC 9726 or 9726-A)
   (_) Mental Health Nurse (AFSC 9721 or 9726)
   (_) Psychiatrist (AFSC 9581, 9586, -A, or -B)

2. Your sex: (_) Male (_) Female

3. Your age: _____ years.

4. Professional degree(s) you hold (please indicate all that apply):
   (_) ADN (_) Diploma in Nursing (_) MSW
   (_) BSN (_) DSW (_) PhD
   (_) BSW (_) MD (_) PsyD
   (_) DNS (_) MN (_) Other (Please specify:_____.)
   (_) MSN

5. Highest degree you hold:
   (_) Associate's (_) MD
   (_) Bachelor's (_) Doctorate
   (_) Master's (_) Other (Please specify:_____.)

6. Field in which you hold your highest degree:
   (_) Behavioral Science
   (_) Biological Science
   (_) Business Administration
   (_) Education
   (_) Medicine
   (_) Nursing
   (_) Personnel Management
   (_) Social Science
   (_) Social Work
   (_) Other (Please specify:_____.)

7. Type of professional certification you hold:
   (_) ACSW
   (_) American Board of Professional Psychology
   (_) American Board of Psychiatry and Neurology
   (_) RNC
   (_) RNCS
   (_) RNCNA
   (_) None
   (_) Other (Please specify:_____.)

8. State in which the institution at which you earned the degree qualifying you for current AFSC was located:_____.

9. Number of years you have practiced since you earned the degree qualifying you for current AFSC: _____ years.

10. Total number of years you have practiced full time: _____ years.

11. The **major** theoretical framework you use in your clinical practice:
   (_) Analytic
   (_) Behaviorist
   (_) Client-Centered
   (_) Cognitive
   (_) Eclectic
   (_) Encounter
   (_) Existential
   (_) Experiential
   (_) Gestalt
   (_) Rational Emotive
   (_) Reality
   (_) Transactional
   (_) None
   (_) Other (Please specify:_____.)

12. Area(s) in which you currently practice (Please indicate all that apply):
   (_) Administration
   (_) CHAP Office
   (_) Children's Mental Health Clinic
   (_) Community Mental Health Consultation
   (_) Inpatient Mental Health Unit
   (_) Inpatient Mental Health Consultation/Liaison
   (_) Medical Social Work Service
   (_) Adult Outpatient Mental Health Clinic
   (_) Student Mental Health Clinic
   (_) Other (Please specify: _____.)

13. Your source(s) of information about PCNS (Please indicate all that apply):
(_) Heard about from other professionals
(_) Read about in the professional literature
(_) Have observed one or more
(_) Have practiced with one or more
(_) Am one
(_) None
(_) Other (Please specify: _____.)

14. Does your present position involve professional contact with a USAF PCNS? (_) Yes (_) No

15. Type(s) of professional contact with a USAF PCNS you have now or have had in the past (Please indicate all that apply):
(_) Cotherapist in group therapy
(_) Cotherapist in family therapy
(_) Multidisciplinary team meeting/rounds
(_) Nursing team conference/rounds
(_) Mental health department committee meetings
(_) Nursing department committee meetings
(_) Received clinical supervision from
(_) Provided clinical supervision to
(_) Precepted by
(_) Preceptor to
(_) Received administrative supervision from
(_) Provided administrative supervision to
(_) Participated in peer practice review meetings with
(_) Received consultation from
(_) Provided consultation to
(_) Collaborated on staff development activities with
(_) Collaborated on research activities with
(_) None
(_) Other (Please specify: _____.)

PART B: The following section lists possible activities for USAF PCNSs in hospital-based settings. Remember that, for the purposes of this study, a PCNS is a mental health nurse with a master's degree in nursing and clinical practice major.

In the first column, "ACTUAL," please circle the number indicating how often you have observed a USAF PCNS perform or be responsible for each activity.

In the second column, "IDEAL," please circle the number indicating how often you believe each activity should be included in the position description (responsibilities) of USAF PCNSs.

1-Never 2-Seldom 3-Sometimes 4-Usually 5-Always

		ACTUAL	IDEAL
1.	Performs outpatient intake interview, including MSE, HX, and current assessmemt.	1 2 3 4 5	1 2 3 4 5
2.	Performs inpatient intake interview, including MSE, HX, and current assessment.	1 2 3 4 5	1 2 3 4 5
3.	Makes diagnoses IAW DSM III.	1 2 3 4 5	1 2 3 4 5
4.	Makes diagnoses IAW Manual of Nursing Diagnosis.	1 2 3 4 5	1 2 3 4 5
5.	Prescribes the mental health treatment plan for a patient.	1 2 3 4 5	1 2 3 4 5
6.	Seeks psychiatric medical consultation for patient medication.	1 2 3 4 5	1 2 3 4 5
7.	Initiates or adjusts medications IAW current protocols.	1 2 3 4 5	1 2 3 4 5
8.	Acts as primary therapist for mental health outpatients.	1 2 3 4 5	1 2 3 4 5
9.	Acts as primary therapist for mental health inpatients.	1 2 3 4 5	1 2 3 4 5
10.	Conducts individual therapy.	1 2 3 4 5	1 2 3 4 5
11.	Conducts group therapy.	1 2 3 4 5	1 2 3 4 5
12.	Conducts family therapy.	1 2 3 4 5	1 2 3 4 5
13.	Serves as professional colleague mental health multidisciplinary team.	1 2 3 4 5	1 2 3 4 5
14.	Serves as subordinate member on mental health multidisciplinary team.	1 2 3 4 5	1 2 3 4 5
15.	Sets standards for inpatient mental health nursing care.	1 2 3 4 5	1 2 3 4 5

16.	Educates patients about their diagnoses and treatments.	1 2 3 4 5	1 2 3 4 5
17.	Educates families about patients' diagnoses and treatments.	1 2 3 4 5	1 2 3 4 5
18.	Directly clinically supervises inpatient mental health nursing staff in patient and therapeutic community management.	1 2 3 4 5	1 2 3 4 5
19.	Directly clinically supervises other mental health professionals.	1 2 3 4 5	1 2 3 4 5
20.	Acts as personal, strong patron of individual nursing staff, shaping their career growth.	1 2 3 4 5	1 2 3 4 5
21.	Personally guides individual nursing staff members, pointing out pitfalls and shortcuts.	1 2 3 4 5	1 2 3 4 5
22.	Acts as official preceptor to new mental health nurses.	1 2 3 4 5	1 2 3 4 5
23.	Directs inpatient mental health nursing staff development program.	1 2 3 4 5	1 2 3 4 5
24.	Bases nursing staff development program on nursing theoretical framework.	1 2 3 4 5	1 2 3 4 5
25.	Bases nursing staff development program on mental health theoretical framework.	1 2 3 4 5	1 2 3 4 5
26.	Directs mental health staff development program.	1 2 3 4 5	1 2 3 4 5
27.	Collaborates as full member of health consultation/liaison team for medical facility.	1 2 3 4 5	1 2 3 4 5
28.	Provides client-centered mental health consultation to non-mental health inpatients.	1 2 3 4 5	1 2 3 4 5
29.	Provides consultee-centered mental health consultation to non-mental health staff.	1 2 3 4 5	1 2 3 4 5

30.	Provides program centered mental health consultation to non-mental health departments.	1 2 3 4 5	1 2 3 4 5
31.	Initiates requests for consultation from other disciplines.	1 2 3 4 5	1 2 3 4 5
32.	Identifies potential areas for nursing research.	1 2 3 4 5	1 2 3 4 5
33.	Identifies potential areas for mental health research.	1 2 3 4 5	1 2 3 4 5
34.	Develops research proposals.	1 2 3 4 5	1 2 3 4 5
35.	Conducts and reports on nursing research.	1 2 3 4 5	1 2 3 4 5
36.	Conducts and reports on mental health research.	1 2 3 4 5	1 2 3 4 5
37.	Administratively supervises inpatient mental health nursing staff.	1 2 3 4 5	1 2 3 4 5
38.	Administratively supervises several areas of nursing service.	1 2 3 4 5	1 2 3 4 5
39.	Administratively supervises mental health staff.	1 2 3 4 5	1 2 3 4 5
40.	Conducts community case finding and screening.	1 2 3 4 5	1 2 3 4 5

PART C: The following items indicate positions in the USAF health care delivery system the PCNS could possibly occupy. Please circle the number that best describes how useful you believe a PCNS in each position would be to the overall efficiency of the USAF health care delivery system.

Position	Definitely not Useful	Possibly Useful	Slightly Useful	Moderately Useful	Very Useful
1. Staff nurse, mental health unit.	1	2	3	4	5
2. Charge nurse, mental health unit.	1	2	3	4	5

3. Supervisor, nursing service.	1	2	3	4	5
4. Staff position in nursing service, not based on one unit.	1	2	3	4	5
5. Staff position in nursing service with mix of unit and non-unit basing.	1	2	3	4	5
6. Staff, nursing staff development services.	1	2	3	4	5
7. Staff, mental health consultation/ liaison team.	1	2	3	4	5
8. Staff, children's mental health clinic.	1	2	3	4	5
9. Staff, adult outpatient mental health clinic.	1	2	3	4	5
10. Staff, student mental health clinic.	1	2	3	4	5
11. Faculty, School of Aerospace Medicine.	1	2	3	4	5
12. Faculty, School of Health Care Sciences.	1	2	3	4	5

COMMENTS: Continue on the reverse if you wish. Please also take a few moments to look over the questionnaire to be sure you have completed all the items and maintained you anonymity.

APPENDIX B
LETTER TO SENIOR MENTAL HEALTH NURSES

XXXXXXXXXX
USAF Medical Center XXXXXXX
XXXXXXX AFB, XX XXXXX-XXXX

XXX XXXXXXX:

Here are the packets I discussed with you on the phone the other day. I greatly appreciate your help in distributing these packets. You have agreed to play a crucial role in helping me complete my master's thesis in mental health nursing.

Each packet consists of an envelope containing a questionnaire and a self-addressed stamped envelope. On the upper right hand corner of each packet is an AFSC code and specialty title. Please give one packet to each person at your facility with the marked AFSC and title, either personally or via their distribution box, until all the packets are gone. If you are unable to distribute all the packets, please let me know on the enclosed return card. Please mail the return card when you have completed distributing the packets.

Again, thank you very much for your help. The time you are taking out from your busy schedule to distribute these packets has been immeasurably important to the completion of my master's thesis in mental health nursing.

Sincerely,

Thomas M. Gormley, BSN, RNC
Capt, USAF, NC
Graduate Student, College of Nursing
University of Florida

APPENDIX C
LETTER TO RESPONDENTS

Dear Air Force Colleague:

As an AFIT sponsored graduate student in mental health nursing at the University of Florida, and in partial fulfillment of my master's degree requirements, I am studying role expectations for USAF Psychiatric Clinical Nurse Specialists (PCNSs) that are held by the PCNSs themselves and by their professional mental health and nursing colleagues. I am inviting you to participate in this study. Your participation is entirely voluntary. Thank you for taking time out from your busy schedule to complete the questionnaire.

The purpose of this research is to examine expectations for the PCNSs' role in USAF hospital-based settings. This information may lead to a better understanding of how others expect PCNSs to "fit in" as well as inform the PCNSs what work they might do to further clarify their role to others.

This research has been approved by both the College of Nursing and the Institutional Review Board of the University of Florida, as well as the USAF (USAF Survey Control Number 85-11). You should be able to complete the full questionnaire in 20 minutes. There are no risks to participation in this study. Your return of a completed questionnaire constitutes your informed consent. There will be no connection between your name and the information you provide. Results of this study will have no direct effect on USAF policy decisions.

Please mail the questionnaire to me within 10 working days. I have enclosed a stamped, self-addressed envelope for your convenience. Before mailing the questionnaire, please inspect it carefully to be sure you have not violated your anonymity and have answered all the questions. Again, thank you for participating in this research.

Sincerely,

Thomas M. Gormley, BSN, RNC
Capt, USAF, NC
Graduate Student, College of Nursing
University of Florida

APPENDIX D
EXPECTATIONS FOR THE IDEAL/EXPECTED HOSPITAL-BASED UNITED STATES AIR FORCE PSYCHIATRIC CLINICAL NURSE SPECIALIST ROLE

	Enactment Behavior	Yes (N = 90)	%	Rank
1.	Performs outpatient intake interview, including MSE[a], HX[b], and current assessmemt.	79	87.778	22
2.	Performs inpatient intake interview, including MSE, HX, and current assessment.	82	91.111	16.5
3.	Makes diagnoses IAW[c] DSM III[d].	60	66.667	37
4.	Makes diagnoses IAW Manual of Nursing Diagnosis.	83	92.222	7
5.	Prescribes the mental health treatment plan for a patient.	74	82.222	29
6.	Seeks psychiatric medical consultation for patient medication.	88	97.778	3.5
7.	Initiates or adjusts medications IAW current protocols.	54	60.000	38
8.	Acts as primary therapist for mental health outpatients.	75	83.333	27
9.	Acts as primary therapist for mental health inpatients.	72	80.000	31
10.	Conducts individual therapy.	73	81.111	30
11.	Conducts group therapy.	87	96.667	5.5
12.	Conducts family therapy.	82	91.111	16.5

13.	Serves as professional colleague mental health multidisciplinary team.	90	100.000	1
14.	Serves as subordinate member on mental health multidisciplinary team.	36	40.000	40
15.	Sets standards for inpatient mental health nursing care.	85	94.444	9
16.	Educates patients about their and treatments.	89	98.889	2
17.	Educates families about patients' diagnoses and treatments.	88	97.778	3.5
18.	Directly clinically supervises inpatient mental health nursing staff in patient and therapeutic community management.	84	93.333	11
19.	Directly clinically supervises other mental health professionals.	63	70.000	34.5
20.	Acts as personal, strong patron of individual nursing staff, shaping their career growth.	83	92.222	13.5
21.	Personally guides individual nursing staff members, pointing out pitfalls and shortcuts.	82	91.111	16.5
22.	Acts as official preceptor to new mental health nurses.	80	88.889	20
23.	Directs inpatient mental health nursing staff development program.	79	87.778	22
24.	Bases nursing staff development program on nursing theoretical framework.	85	94.444	8.5
25.	Bases nursing staff development program on mental health theoretical framework.	83	92.222	13.5
26.	Directs mental health staff development program.	63	70.000	34.5

27.	Collaborates as full member of health consultation/liaison team for medical facility.	87	96.667	5.5
28.	Provides client-centered mental health consultation to non-mental health inpatients.	79	87.778	22
29.	Provides consultee-centered mental health consultation to non-mental health staff.	75	83.333	27
30.	Provides program centered mental health consultation to non-mental health departments.	77	85.556	24.5
31.	Initiates requests for consultation from other disciplines.	75	83.333	27
32.	Identifies potential areas for nursing research.	84	93.333	11
33.	Identifies potential areas for mental health research.	84	93.333	11
34.	Develops research proposals.	81	90.000	19
35.	Conducts and reports on nursing research.	82	91.111	16.5
36.	Conducts and reports on mental health research.	77	85.556	24.5
37.	Administratively supervises inpatient mental health nursing staff.	71	78.889	32
38.	Administratively supervises several areas of nursing service.	61	67.778	36
39.	Administratively supervises mental health staff.	52	57.778	39
40.	Conducts community case finding and screening.	70	77.778	33
	Positions			
1.	Staff nurse,mental health unit.	72	80.000	10

2. Charge nurse, mental health unit.	81	90.000	2.5
3. Supervisor, nursing service.	78	86.667	5
4. Staff position in nursing service, not based on one unit.	71	78.889	11
5. Staff position in nursing service with mix of unit and non-unit basing.	74	82.222	9
6. Staff, nursing staff development services.	75	83.333	8
7. Staff, mental health consultation/liaison team.	87	96.667	1
8. Staff, children's mental health clinic.	79	87.778	4
9. Staff, adult outpatient mental health clinic.	81	90.000	2.5
10. Staff, student mental health clinic.	76	84.444	6
11. Faculty, School of Aerospace Medicine.	65	72.222	12
12. Faculty, School of Health Care Sciences.	76	84.444	7
Total Expectations:	52		

[a]Mental Status Examination
[b]History
[c]In Accordance with
[d]Diagnostic and statistical manual of mental disorders (3rd. ed) (American Psychiatric Association, 1980)

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BIOGRAPHICAL SKETCH

Thomas M. Gormley was born on 8 November, 1946, in Washington, DC. He graduated from Gonzaga College High School, Washington, in 1964, and received a bachelor's degree in zoology from the University of Maryland, College Park, in January 1969. After serving in the United States Army, he returned to academia, earning a Bachelor of Science in Nursing from the University of Maryland, Baltimore, in 1975. He has been a commissioned officer in the United States Air Force since 1 July 1976, and has served both as a generalist mental health nurse and flight nurse in the United States and overseas. He is married, with two children. Professionally, he is interested in psychiatric/mental health nursing, with an emphasis on clinical management of inpatient therapeutic communities and consultation/liaison services.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a thesis for the degree of Master of Science in Nursing.

Martha J. Snider,
Associate Professor of Nursing

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a thesis for the degree of Master of Science in Nursing.

Joy H. Davis,
Associate Professor of Nursing

This thesis was submitted to the Graduate Faculty of the College of Nursing and to the Graduate School, and was accepted as partial fulfillment of the requirements for the degree of Master of Science in Nursing.

May, 1986

Dean, College of Nursing

Dean, Graduate School

FROM: CIMI 19 February 1986

SUBJECT: Thesis Transmittal - Capt Thomas M. Gormley, USAF, NC

TO: NR

1. The attached thesis entitled "Role Expectations for United States Air Force Psychiatric Clinical Nurse Specialists" by Capt Thomas M. Gormley, USAF, NC is forwarded for your review and action. I would recommend the following individual as reviewer:

Col Carolyn Schneider, USAF, NC
HQ USAF/SGN
Bolling AFB DC 20332

2. Thank you for your assistance.

GARY D. McMANN, Capt, USAF, MSC
Program Manager, Health Care Educ Div
Civilian Institution Programs

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Thesis

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